Dartmouth Health

NH Health Access NETWORK
financial help – for your health

Dear Applicant:

If payment of your healthcare expenses could create a financial hardship for you, please fill out this application.

This application will help us determine our ability to reduce those expenses for services provided at any Dartmouth Health location. Please answer all questions that apply to you or your household. Any information you provide is confidential and is reviewed only by the staff processing your application.

If you have insurance then you may also be eligible for financial assistance with other participating providers of the NH Health Access Network. The NH Health Access Network is a network of hospitals and other health care providers that work to improve access to healthcare for under-insured children and adult residents of the State of New Hampshire.

Before any financial assistance is granted, you must have already exhausted all other sources of payment including insurance, public assistance, litigation or third-party liability. Please use the checklist below to be sure you have included all the information.

		Required	N/A
1.	A complete copy of your most recent Federal Income Tax Return and all schedules	◯	◯
2.	Copies of all most recent W-2 forms	◯	◯
3.	Copies of the three (3) most recent paycheck stubs or a statement from employer(s)	◯	◯
4.	Copies of three (3) most recent bank statements (e.g., savings, checking, money Market funds, IRA, 401K, etc.)	◯	◯
5.	Copies of unemployment, disability compensation benefits statements	◯	◯
6.	Copies of social security and/or pension benefits	◯	◯
7.	Copy of Food Stamp allocation	◯	◯
8.	Copies of dividend sources, trust funds and property tax statements	◯	◯
9.	Copies of government assistance notices;		
	- Department of Health & Human Services notices (all pages)	◯	◯
	- Medicaid Spend Down Letters, Copies of Denial Notices from Medicaid	◯	◯
	- Notices from Premium Assistance Plan(s) and Marketplace Insurance(s)	◯	◯

You will continue to be financially responsible for any services you receive until your completed application is received. If you have not heard from us in 30 days after returning your application, or you need help completing the application, please call one of our Patient Advocates at (844) 647-6436. **Office hours are 9 am – 4:30 pm, Monday – Friday.**

Completed applications should be returned to one of the addresses below:

Dartmouth Hitchcock Medical Center
One Medical Center Drive
PFS: Level 3 FAA
Lebanon, NH 03756
Fax: (603) 640-1913

New London Hospital
PO Box 2150
Attn: Financial Counselor
New London, NH 03257
Fax: (603) 643-7364

Cheshire Medical Center
580 Court Steet
PFS: FAA
Keene, NH 03431
Fax: (603) 643-7363

Visiting Nurse and Hospice for Vermont and New Hampshire (VNH)
88 Prospect St.
White River Junction, VT 05001
Fax: (603) 640-1913

Alice Peck Day Memorial Hosptial
10 Alice Peck Day Drive
FAA
Lebanon, NH 03766
Fax: (603) 640-1913

You can receive in person assistance completing this application at the following locations:

Dartmouth Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756
(603) 650-6222

Dartmouth Hitchcock Clinics Manchester
100 Hitchcock Way
Manchester, NH 03104
(603) 629-8293

Cheshire Medical Center
580 Court Street
Keene, NH 03431
(603) 354-5430

New London Hospital
273 County Road
New London, NH 03257
(603) 526-5082

Dartmouth Hitchcock Clinics Concord
253 Pleasant Street
Concord, NH 03301
(603) 229-5080

Dartmouth Hitchcock Clinics Nashua
2300 Southwood Drive
Nashua, NH 03063
(603) 577-4055

Alice Peck Day Memorial Hospital
10 Alice Peck Day Drive
Lebanon, NH 03766
(603) 308-0007

Dartmouth Health

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Financial Assistance Application

1. Patient Information

Last Name | *First Name* | *Middle Initial* | *Social Security #* | *Date of Birth*

Street Address | *City* | *State* | *Zip code* | *Length of time at address*

Mailing Address | *City* | *State* | *Zip code*

Home Phone Number *Work Phone Number*

☐ *Single* ☐ *Married* ☐ *Civil Union*
☐ *Separated* ☐ *Divorced* ☐ *Widowed*
☐ *US Citizen* ☐ *NH Resident*

2. Person Responsible for Paying the Bill

Last Name | *First Name* | *Middle Initial* | *Relationship to Patient* | *Social Security #*

Address if Different From Patient's | *Home Phone Number* | *Work Phone Number*

Name of Insurance Company | *Effective Date*

3. Please indicate ALL people living in the household, including applicant: Use additional sheet of paper if needed

	Name	*Relationship to Patient*	*Date of Birth*	*Social Security #*	*Applying Yes/No*
1	**Self**				
2					
3					
4					
5					
6					

4. Is this application for future or past services?

☐ Future ☐ Past *Date(s) of Services:* _____

5. Please fill out if anyone in your household has insurance:

Health insurance (Plan/Name), _____ *Health savings account(circle)* Yes No *Who:* _____

Policy #/ID# _____ *Deductible Amount:* _____

Medicare Part A ____, *Medicare Part B*_____, *Receives assistance to pay Medicare Part B* _____, *Who:* _____

6. Has anyone in your household applied for Medicaid? ☐ Yes ☐ No Who: _____

If Yes and denied please provide copy of the Medicaid denial notice.

7. Have you applied for financial assistance at another facility? ☐ Yes ☐ No *If yes, where:* _____

8. Is anyone in your household pregnant? ☐ Yes ☐ No

9. Has anyone in your household served in the military? ☐ Yes ☐ No *Who:* _____

10. Have you recently filed a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No *Date:* ___

11. Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No *Who:* _____

12. Does anyone else claim you on their income tax return? ☐ Yes ☐ No *Who:* _____

13. Household Asset Information

	Person 1	Person 2	Person 3
Name of each household member:	_____	_____	_____
Name of employer:	_____	_____	_____
Gross Monthly Income From:			
Employment:	$ _____	$ _____	$ _____
Self-Employment:	$ _____	$ _____	$ _____
Investment Accounts:	$ _____	$ _____	$ _____
Real Estate rentals:	$ _____	$ _____	$ _____
Unemployment:	since MM / DD / YYYY	since MM / DD / YYYY	since MM / DD / YYYY
Retirement:	$ _____	$ _____	$ _____
(Soc. Security, Pension, Annuity)			
Alimony/Child Support:	$ _____	$ _____	$ _____
Public Assistance, Food Stamps:	$ _____	$ _____	$ _____
Other Income:	$ _____	$ _____	$ _____
Savings and Investments:			
Checking Account Balances:	$ _____	$ _____	$ _____
Savings & CD Account Balances:	$ _____	$ _____	$ _____
(IRAs, 403B, 401K:)			
Specify: _____	$ _____	$ _____	$ _____
Other savings and investments:			
Specify: _____	$ _____	$ _____	$ _____

14. Household Expences

Monthly Rent Payment: $* _____ *Mortgage Payment:$ _____ *Mortgage Loan Balance $* _____

Property Tax Amount Not Included in Payment Amount Above: $ _____ *Value of Home: $* _____

Do You Own Property Other Than Primary Residence? ☐ Yes ☐ No

If Yes, Value $ _____ *Mortgage balance: $* _____

If other property is a business, list address: _____ *Monthly Loan Payment: $* _____

Paid to: _____ *For:* _____

Medicare Part D deducted from Social Security check: ☐ Yes ☐ No *Amount:$* _____

Utilities $ _____ *Insurance (Auto/Life/Property) $* _____ *Other: $* _____

Alimony/Child Support $ _____ *Health Insurance Premium $* _____ *Other: $* _____

Child Care $ _____ *Healthcare Bills $* _____ *Other: $* _____

Living (gas, food, clothes) $ _____ *Medications $* _____ *Other: $* _____

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined. In the event that I have not fully disclosed, or have inaccurately represented, any income or assets, any agreement to provide you with a charitable care discount would be null and void and would be retroactive back to the date the bills were owed. I may be liable for any/all legal fees during the collection process.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures might not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

Applicant Signature _____ Date _____

Co-Applicant Signature_____ Date _____