

Dear Applicant:

If payment of your health care 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-Hitchcock, Cheshire Medical Center, Alice Peck Day Memorial Hospital or New London Hospital 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 than 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 health care 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.	<input type="checkbox"/>	<input type="checkbox"/>
2. Copies of all most recent W-2 forms.	<input type="checkbox"/>	<input type="checkbox"/>
3. Copies of the three (3) most recent paycheck stubs or a statement from employer(s)	<input type="checkbox"/>	<input type="checkbox"/>
4. Copies of three (3) most recent bank statements (e.g., savings, checking, money Market funds, IRA, 401K, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Copies of unemployment, disability compensation benefits statements	<input type="checkbox"/>	<input type="checkbox"/>
6. Copies of social security and/or pension benefits	<input type="checkbox"/>	<input type="checkbox"/>
7. Copy of Food Stamp allocation	<input type="checkbox"/>	<input type="checkbox"/>
8. Copies of dividend sources, trust funds and property tax statements	<input type="checkbox"/>	<input type="checkbox"/>
9. Copies of government assistance notices;		
Department of Health & Human Services notices (all pages)	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Spend Down Letters, Copies of Denial Notices from Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
Notices from Premium Assistance Plan(s) and Marketplace Insurance(s)	<input type="checkbox"/>	<input type="checkbox"/>

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 9:00 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) 650-6142	Cheshire Medical Center 580 Court Steet. PFS: FAA Keene, NH 03431 FAX: (603) 354-6596	Alice Peck Day Memorial Hospital 10 Alice Peck Day Drive. FAA Lebanon, NH 03766 FAX: (603) 448-5135
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New London Hospital PO Box 2150 Attn: Financial Counselor New London, NH 03257 FAX: (603) 526-5085	Newport Health Clinic 11 John Stark Highway Attn: Financial Counselor Newport, NH 03773 FAX: (603) 526-5085
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# Financial Assistance Application


**1. Patient's Information:**

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Social Security Number</i>	<i>Date of Birth</i>
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<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip code</i>	<i>Length of time at address</i>
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<i>Mailing Address</i>	<i>City</i>	<i>State</i>	<i>Zip code</i>	
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 Single     Married     Civil Union

<i>Home Phone Number</i>	<i>Work Phone Number</i>	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
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 US Citizen     NH Resident

**2. Person Responsible for Paying the Bill**

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Relationship to Patient</i>	<i>Social Security Number</i>
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<i>Address if Different From Patient's</i>	<i>Home Phone Number</i>	<i>Work Phone Number</i>
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<i>Name of Insurance Company</i>	<i>Effective Date</i>
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**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	SOC. SECURITY#	Applying Yes/No
1	<b>Self</b>			
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 INFORMATION	PERSON 1	PERSON 2	PERSON 3
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\*NAME of each household member: \_\_\_\_\_

Name of employer: \_\_\_\_\_

**Gross Monthly Income From:**

Employment: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Self-Employment: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Investment Accounts: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Real Estate rentals: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Unemployment: (since \_\_\_ / \_\_\_ / \_\_\_) \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

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: \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Other:** \_\_\_\_\_

Automobile: Year, Make, Model? \_\_\_\_\_

Recreational Vehicle: Year, Make, Model? \_\_\_\_\_

14. HOUSEHOLD EXPENSES
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Monthly Rent Payment: \$ \_\_\_\_\_ or 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: \_\_\_\_\_ \$ \_\_\_\_\_

15. ASSIGNMENT OF RIGHTS <i>Read Carefully</i>
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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

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

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

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

Alice Peck Day Memorial Hospital  
10 Alice Peck Day Drive  
Lebanon, NH 03766  
(603) 443-9579

Dartmouth-Hitchcock Manchester  
100 Hitchcock Way  
Manchester, NH 03104  
(603) 695-2692

New London Hospital  
273 County Road  
New London, NH 03257  
(603) 526-5183

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

Newport Health Clinic  
11 John Stark Highway  
Newport, NH 03773  
(603) 526-5183