



Dear Applicant:

Please fill out this application if it is hard to pay for your health care.

This application helps us decide if we can reduce your health care costs for services at Dartmouth Health locations. Please answer all questions for you and your household. Your information is confidential. It will only be shared with the staff who process your application.

If your income and immigration status qualify for Medicaid, you will need to apply. We can help you do this. If you are in an accident, you will need to exhaust other sources of payment, like third-party liability.

We need proof of your income and liquid assets to see if you qualify for financial assistance. Please provide the following:

Required Documents

- **Income:** Complete copy of your most recent Federal Income Tax Return and all schedules and forms (e.g. 1040, 1099, etc.)
Note: if you do not file taxes or this does not reflect your current income, please see alternative documentation options below.
- **Liquid Assets:** Copy of two (2) most recent bank or other financial statements (e.g., savings, checking, money market, etc.) for each account held by a person applying on the application.

Alternative Income Documentation

- **If employed:** Copies of two (2) most recent pay stubs from all employers for each person applying on the application.
If not available, please supply a written statement from employer with income information.
- **If unemployed:** Copy of unemployment benefits statement if applicable (e.g., check, bank statement, online, etc.).
- **If self-employed:** Profit and Loss statement for the last 3 months.
- **If you own a rental property:** Rental Income – copy of current Schedule E of IRS form.
- **If you receive social security disability benefits:** Copy of disability compensation benefit statement/award letter or check, bank statement, online, etc.
- **If you receive social security, pension, retirement income:** Copy of your award letter, check stub, bank statement, etc.
Note: Supplemental Security Income does not need to be provided.
- **Other types of income:** If you receive income not listed here, please call our Patient Advocates at 844-647-6436 to determine the needed documentation.

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.**

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 Concord
253 Pleasant Street
Concord, NH 03301
603-229-5080

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

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

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

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

New London Hospital
273 County Road
New London, NH 03257
603-526-5503

Mt. Ascutney Hospital and Health Center
298 County Road
Windsor, VT 05089
802-674-7233

Valley Regional Hospital
243 Elm Street
Claremont, NH 03743
603-543-6947

Completed applications should be returned to the address below:

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

Financial Assistance Application

1. Patient Information

Last Name	First Name	Middle Initial	SSN#	Date of Birth
Street Address		City	State	ZIP
Mailing Address (if different than above)		City	State	ZIP
Home Phone Number		Work Phone Number		
☐ Single ☐ Married ☐ Civil Union ☐ Separated ☐ Divorced ☐ Widowed				

2. Please list all dependents who live in your tax household.

(Household is defined as self, spouse/domestic partner, and all tax dependents.)

	Name	Relationship to Patient	DOB	SSN#	Applying Yes/No
1	Self				
2					
3					
4					
5					
6					

3. Is this application for future or past services? ☐ Future ☐ Past Date(s) of Services: _____

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

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

Policy #/ID# _____ Deductible Amount: _____

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

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

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

6. Is anyone in your tax household pregnant? ☐ Yes ☐ No

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

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

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

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

11. Tax Household Income/Liquid 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: (from settlements before 2019)	\$ _____	\$ _____	\$ _____

Savings and Liquid Assets:

Checking Account Balances:	\$ _____	\$ _____	\$ _____
Savings & CD Account Balances:	\$ _____	\$ _____	\$ _____
Other liquid savings and investments:			
Specify: _____	\$ _____	\$ _____	\$ _____

Additional Information

Please include any other information about your current financial situation that you would like us to know, such as, difficulty paying for bills, rent or food.

By signing below I authorize the request for my 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 liquid 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 may need to apply to that program and provide proof of application.

Applicant Signature

Date

Co-Applicant Signature

Date