Dear Applicant:

You may be able to get financial help from New London Hospital and possibly other NH Health Access Network providers.

The NH Health Access Network is a group of hospitals, doctors and other health care providers in New Hampshire that work together to help children and adults when they can't afford the health care they need.

To get financial help through the NH Health Access Network, you must have tried to get, and been refused, all other sources of payment including insurance, public assistance, or a lawsuit.

To find out if you or your household qualifies, you must give us proof of your income. Please fill out the attached application and sign it. Then, please send us that application and a COPY of each of the following for your household:

1. Complete copy of your most recent Federal Income Tax Return and all schedules. ☐
2. Last year's W-2 forms ☐
3. Copies of the three (3) most recent, consecutive paycheck stubs or a statement from the employer ☐
4. Copies of three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) ☐
5. Copies of unemployment or disability compensation benefits statements ☐
6. Copies of pension benefits stubs ☐
7. Copies of social security income (yearly benefits statements, copy of check or direct deposit) ☐
8. Copy of Food Stamp allocation ☐
9. Copies of government assistance notices (including Department of Health & Human Services) ☐

Please use this checklist to be sure we have all the information we need to quickly and correctly process your application. We may ask you for additional information about your credit evaluation and income tax return. The information you provide is confidential.

You will continue to be financially responsible for any services you receive until we have learned whether you qualify for help.

If you have not heard from us in 30 days after returning your application, or you need help in understanding it, please call Claire Boyd at 526-5278.

Financial Assistance Application

1. Patient's Information:

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

Street Address | *City* | *State* | *Zip code*

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

Home Phone Number | *Work Phone Number*

check one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

2. Person Responsible for Paying the Bill

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

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*	*SOC. SECURITY#*	*DOCTOR'S NAME*
1		**Self**			
2					
3					
4					
5					
6					

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

5. Has anyone in your household applied for NH Healthy Kids or Medicaid? ☐ Yes ☐ No Who:______________________

When?_______________ What is the status? ☐ Pending ☐ Denied Reason:_____________________________________

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

7. Has anyone in your 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 household eligible for Social Security benefits? ☐ Yes ☐ No Who:______________________________

10. Is anyone in your household covered by health insurance or a health savings account (HSA)?

☐ Yes ☐ No Who:_____________________________

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

12. HOUSEHOLD INFORMATION

	PERSON 1	PERSON 2	PERSON 3
***NAME of each household member:**	______	______	______
Name of employer:	______	______	______
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:			
Value of Automobile:	$ ______	$ ______	$ ______
What is the Year, Make, Model?	______	______	______
Value of Recreation Vehicle: What is the Year, Make, Model?	______	______	______

13. HOUSEHOLD EXPENSES

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, What is the Value? $______________

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	$ ______	Other: ______	$ ______
Child Care	$ ______	Healthcare Bills	$ ______	Other: ______	$ ______
Living (gas, food, clothes)	$ ______	Medications	$ ______	Other: ______	$ ______

14. ASSIGNMENT OF RIGHTS *Read Carefully*

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.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

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 may 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* *C0-Applicant Signature* *Date*

2007 FEDERAL POVERTY INCOME GUIDELINES

To be eligible for 100 percent approval for the New London Hospital Financial Assistance Program, family income must be less than or equal to the levels reflected in the 200 percent column. To be eligible for 75 percent approval for the New London Financial Assistance Program, family income must be greater than the 200 percent column, but less than equal to the levels reflected in the 250 percent column. To be eligible for 50 percent approval for the New London Hospital Financial Assistance Program, family income must be greater than the 250 percent column, but less than or equal to the levels reflected in the 300 percent column. To be eligible for the 25 percent approval for the New London Hospital Financial Assistance Program, family income must be greater than the 300 percent column, but less than or equal to the levels reflected in the 400 percent column. If family income is greater than levels shown in the 400 percent column, you will not qualify for the NLH Financial Assistance Program.

Size of Family	2007 Federal Poverty Income Guidelines	200 percent	250 percent	300 percent	400 percent
1	$10,210	$20,420	$25,525	$30,630	$40,840
2	$13,690	$27,380	$34,225	$41,070	$54,760
3	$17,170	$34,340	$42,925	$51,510	$68,680
4	$20,650	$41,300	$51,625	$61,950	$82,600
5	$24,130	$48,260	$60,325	$72,390	$96,520
6	$27,610	$55,220	$69,025	$82,830	$110,440
7	$31,090	$62,180	$77,725	$93,270	$124,360
8	$34,570	$69,140	$86,425	$103,710	$138,280

For family units with more than 8 members, add $3480 for each additional member. All poverty income levels refer to total annual cash receipts from all sources before taxes. The 2007 update of the poverty income guidelines was published by the Federal Department of Health and Human Services in the Federal Register.

The definition of family for purposes of New London Hospital Financial Assistance Program eligibility is as follows: a unit of not more than two adults and his/her children under the age of 18 living in a single household or claimed as dependents for federal income tax purposes.

Revised 3/1/07