

Dear Applicant:

You may be able to get financial help from New London Hospital and possibly other healthcare organizations.

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 cannot afford the health care they need.

To get financial help through the NH Health Access Network with out-of-pocket expenses you must have active insurance accepted by and in-network with the provider. Financial assistance may be available for those who do not have insurance, please contact a financial counselor at New London Hospital **(603) 526-5292**.

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:

<b>Documentation</b>	<b>Attached</b>	<b>Not Required</b>
Complete copy of your most recent Federal Income Tax Return and all Schedules		
Copies of most recent W-2 forms		
Copies of the three (3) most recent, consecutive paycheck stubs or a statement from the employer.		
Copies of the three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) <b>ALL PAGES</b>		
Copies of unemployment or disability compensation benefits Statements		
Copies of pension benefits stubs		
Copies of social security income (yearly benefits statements, copy of check or direct deposit)		
Copy of Food Stamp allocation		
Copies of government assistance notices (including Department of Health & Human Services and Medicaid Spend Down Letter)		
<u>Copies of Denial Notices from Medicaid, including Premium Assistance Plan</u>		
<u>Copies of financial subsidies notices from Marketplace</u>		

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 services received until we have learned whether you qualify for help. If you have not heard from us in 60 days after returning your application, or you need help in understanding it, please call a Financial Counselor at 603-526-5292.

Sincerely,  
Financial Counseling  
New London Hospital\Newport Health Center

Return the application and requested documents to the Financial Counseling office at:

New London Hospital  
273 County Road  
PO Box 2150  
New London, NH 03257  
-@ the Emergency Room Entrance

-OR-

Newport Health Center  
11 John Stark Highway  
Newport NH 03773  
-2<sup>nd</sup> Floor next to Check-out

**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>
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>Zip code</i> <i>Length of time at address</i>
<i>Mailing Address</i>		<i>City</i>	<i>State</i>	<i>Zip code</i>
<i>Home Phone Number</i>		<i>Work Phone Number</i>		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> US Citizen <input type="checkbox"/> 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>
<i>Address if Different From Patient's</i>			<i>Home Phone Number</i>	<i>Work Phone Number</i>
<i>Name of Insurance Company</i>			<i>Effective Date</i>	

**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
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