



**Financial Counselor phone number: 603-281-6630**

Dear Applicant:

You may be able to get financial help from Southern New Hampshire Health.

To find out if you or your household qualifies for insured or, otherwise, for financial assistance through your provider, 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 any services you receive until we know 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 603-281-6630.

**Please return the application and requested documents to:**

Southern New Hampshire Medical Center  
 Financial Counseling Services  
 Cashier's Office  
 8 Prospect St.  
 Nashua, NH 03060 PO Box 2014

## 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 Length of time at address

\_\_\_\_\_  
 Mailing Address City State Zip code

\_\_\_\_\_  
 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 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#	Applying Yes/No
1	<b>Self</b>			
2				
3				
4				
5				

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** *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. 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.

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*Applicant Signature*

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*Date*

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*CO-Applicant Signature*

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*Date*