NC | Androscoggin Valley Hospital

Dear Patient:

If payment of health care expenses could create a financial hardship please complete the attached application if you have or had a planned, scheduled, non-emergent service and are a resident living in Coos, Grafton or Carroll County in NH, Oxford County, ME or Essex County, VT. If you had unscheduled services, no resident requirements apply. For more information, please contact Customer Service Department Personnel by calling 603-326-5628 or visit the Customer Service Department located on the first floor of the hospital. Look for the Customer Service/Financial Counseling signs.

The application and supporting documentation required will help us determine if you are eligible for financial assistance at Androscoggin Valley Hospital (AVH) and/or Androscoggin Valley Surgical Associates (ASA). This is an income and asset based program. **Any information provided is confidential.** Please use the check list below to ensure all the necessary information needed to process the application has been included/or ***all members living in the household and/or included on the Federal Income Tax Return.***

Please call if clarification is needed prior to submitting the application at the telephone numbers listed above.

1. Completed application signed by all household/family members 18 years or older. 0

2. Proof of residency - driver's license or non-driver ID will be required if address on supporting documentation is not within the service areas listed above. 0

3. **Complete** copy of most recent Federal Income Tax Return(s) (i.e. 2020 return will be accepted until April 18, 2021 unless 2021 return is available) WITH ALL schedules AND W-2's. **0**

4. Copy of the four (4) most recent consecutive paycheck stubs or a statement from employer showing the gross income total for one month. **0**

5. Copy of **ALL pages** of the three (3) most recent bank statements (i.e. savings, checking, money market account, certificate of deposit). Verification of deposits over $5000 may be required. **0**

6. Copy of most recent retirement or investment statements (i.e. 401K, 403B, IRA, Mutual Fund, stocks, bonds). **0**

7. Copy of all income sources (i.e. annual social security, Veteran's (VA) or pension benefit letters, unemployment or workers compensation letter, disability compensation benefitstatements, etc.). **0**

8. Copy of medical assistance letter (i.e. Dept. of Health and Human Services) or health insurance card. **0**

9. Copy of current property tax bill with assessed value AND copy of mortgage statement with current outstanding balance for property excluding primary residence (i.e. 2nd home, cottage, camp, land, rental etc.). 0

You will continue to be financially responsible for any services you receive until eligibility is determined. If you have not received a determination within thirty (30) days of submitting your completed application and supporting information, or if you need help completing the application, please contact the Customer Service Department at 603-326-5628.

Completed applications and supporting documents should be returned to: Androscoggin Valley Hospital, Attention: Customer Service Department, 59 Page Hill Road, Berlin, NH 03570.

Financial Assistance Application

NCH north country healthcare | Androscoggin Valley Hospital

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 | Other Phone Number

Marital Status (circle one):

Single	Married	Civil Union	Separated	Divorced	Widowed

Citizenship Status (circle one):

U.S. Citizen	VT Resident	NH Resident

2. Person Responsible for Paying the Bill

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

Street Address | City | State | Zip Code

3. Household Information

** Please indicate ALL people living in the household, including the applicant: (Use additional sheet of paper if needed)

Name	Relationship to Patient	Date of Birth	Social Security #	Applying for assistance?
1.				YES / NO
2.				YES / NO
3.				YES / NO

A. Is this application for future or past services? (circle) **FUTURE / PAST**

B. Does anyone in your household have insurance? (circle) **YES / NO**

Health Insurance Policy Name:

Policy / ID #:

Health Savings Account? (circle) **YES / NO**

C. Has anyone in your household applied for Medicaid? (circle) **YES / NO**

D. Have you applied for financial assistance at another facility? (circle) **YES / NO** If yes, where?

E. Is anyone in your household pregnant? (circle) **YES / NO**

F. Has anyone in your household served in the military? (circle) **YES / NO**

G. Have you recently filed a workers' compensation or motor vehicle accident claim? (circle) **YES / NO** If yes, when:

H. Is anyone in your household eligible for Social Security Benefits? (circle) **YES / NO**

I. Does anyone in the household pay child support? (circle) **YES / NO** If yes, monthly amount paid:

J. Does anyone else claim you on their income tax return? (circle) **YES / NO** If yes, who:

K. Are there any adults in the household who do not have any income? (circle) **YES / NO** If yes, who:

L. Are there any adults in the household who do not have any bank accounts? (circle) **YES / NO** If yes, who:

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4. Household Income Information

	Person 1	Person 2	Person 3
Name of each household member:			
Name of your employer:			
Gross Monthly Income from:			
Employment:			
Self-Employment:			
Investment Accounts:			
Real-Estate rentals:			
Unemployment:			
Retirement: (Social Security, pension, annuities)			
Alimony / Child Support:			
Other income:			
Savings and Investments:			
Checking Account Balances:			
Savings & CD Account Balances:			
IRA, 401k, 403b Balances:			
Other savings & investments:			
Other:			
Automobile (Year, Make, Model)			
Recreational Vehicle (Year, Make Model)			

5. Household Expenses

Do you own property other than your primary residence? (circle) **YES / NO** If yes, additional information may be requested

Monthly Rent Payment:_____
Monthly Mortage Payment:_____
Medicare Part B, Part C, or Part D deducted from Social Security Check: _____

6. 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.

Applicant Signature **Date**

Co-Applicant Signature **Date**

Application Addendum

PLEASE ANSWER THE FOLLOWING QUESTIONS TO ASSIST US IN MAKING A DETERMINATION ON YOUR APPLICATION.

If the question does not pertain please answer N/A.

If you are currently unemployed, when was your last day of work?_____

Are you eligible for unemployment compensation?_____

If you are temporarily out of work, do you expect to return to the same job?_____

If so, when?_____

Are you a parent who is unable to work because of health reasons?_____

Are you a single parent with more than 50% custody of your child/children?_____

Do you receive Social Security benefits as a result of a disability?_____

Do you have health problems that limit your ability to work?_____

Do you have a whole life insurance policy?_____

If you did not enclose a copy of last year's tax return, please indicate the reason why:

___ Do not have to file - retired.

___ Did not make enough money to file.

___ Did not keep a copy of last year's tax return.
Please contact us at 326-5628 to request a transcript of tax return form.

Authorization to Release Information

I hereby authorize and request:

Name and Address of Individual or Agency Providing the Information

The NH Department of Health and Human Services
Berlin District Office, Littleton District, other district office, and/or Central Medicaid Unit

to provide the following information: The status of my application for assistance and/or what information maybe still required for a determination to be made. A copy of my notice of decision(s), information (verbal and/or written) regarding my eligibility, approval, or denial for all programs. The amount of my monthly spend down. Information regarding why my case closed.

to:

Name and Address of Individual or Agency Receiving the Information

Androscoggin Valley Hospital, ATTN: Customer Service Department,
59 Page Hill Road, Berlin, NH 03570

Fax: 603-326-5658, Telephone: 603-326-5628

I grant my permission for the reproduction of the above information to be given to the individual or agency names. Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the specified information to the individual/agency I have named.

This authorization expires **in one year**

(Date)

Information released cannot be re-released by the receiving individual/agency without additional authorization.

(Signature) (Date)

(Printed Name) (Date of Birth)

If the signature above is not that of the person to whom the information pertains, the relationship of the signer to that person must be indicated. In addition, the signature must be witnessed.

(Relationship) (Witness)

(Date)

PATIENT- YOU MUST KEEP THIS PAGE FOR COVERAGE REFERENCE

Excluded Procedures/Services/Supplies for Reduced Charges

Bariatric medicine: exercise programs (payment is due prior to service).

Cosmetic procedures/services (physician services and related hospitalization), including charges for plastic and cosmetic surgery, botox injections, laser treatment (i.e. hair removal, spider veins, facial and neck, wrinkle reduction, pigmented lesions, etc.).

Dental services.

Diabetic Education for weight loss only. Must have valid diagnosis (i.e. diabetes, renal disease)

Experimental/Investigational procedures (i.e. fertility treatment and testing) except initial physician consultation charge.

Insurance company claims denied for lack of referral/pre-certification that the patient is required to obtain or for patient failure to submit information being required by the insurance company.

Occupational Health Services.

Physical exams and related services for work or insurance purposes or as required for other administrative or liability reasons.

Services or procedures for any condition, disease or injury arising out of or in the course of employment, when the member has the opportunity to be covered by a Workers' Compensation Program.

Services or procedures as a result of any accident covered by any liability insurance.

Sex transformation procedures and related services.

Sterilization and/or reversal of voluntary sterilization charges. Physician consultation charges for discussion of possible sterilization and/or reversal will be covered.

Supplies, including but not limited to: hearing aid(s) and batteries, custom or other earplugs, swimming headband, botox serum, cast cover, durable medical equipment.

Provider List

The Androscoggin Valley Hospital (AVH) and Androscoggin Valley Hospital Surgical Associates (ASA) Financial Assistance Policy will not be applied to charges for emergency and medically necessary care rendered at AVH/ASA if those charges are not billed by AVH/ASA for the provider.

Providers, from other facilities, providing emergency and medically necessary care at AVH/ASA are not covered under the AVH/ASA financial assistance policy and charges for their services will be billed by their facility.

Covered and non-covered provider facilities are listed below:

Covered

Androscoggin Valley Hospital
Androscoggin Valley Hospital Surgical Associates

Non-Covered

Catholic Medical Center/New England Heart Institute
Coos County Family Health Services
Dartmouth Hitchcock Medical Center
Eyesight Ophthalmic Services
I Rhythm
Implantable Product Group (IPG)
Littleton Regional Health Care
Memorial Hospital
North Country Dental
North Country Radiology
Upper Connecticut Valley Hospital
Weeks Medical Center