Dartmouth-Hitchcock Health

NH Health Access NETWORK
financial help – for your health

Dear Applicant:

If payment of your health care expenses could create a financial hardship for you, please fill out this application. This application will help us determine our ability to reduce those expenses for services provided at any Dartmouth-Hitchcock, Cheshire Medical Center or Alice Peck Day Memorial Hospital location. Please answer all questions that apply to you or your household. Any information you provide is confidential and is reviewed only by the staff processing your application.

If you have insurance than you may also be eligible for financial assistance with other participating providers of the NH Health Access Network. The NH Health Access Network is a network of hospitals and other health care providers that work to improve access to health care for under-insured children and adult residents of the State of New Hampshire.

Before any financial assistance is granted, you must have already exhausted all other sources of payment including insurance, public assistance, litigation, or third-party liability. Please use the checklist below to be sure you have included all the information.

	Required	N/A
1. A complete copy of your most recent Federal Income Tax Return and all schedules.	☐	☐
2. Copies of all most recent W-2 forms.	☐	☐
3. Copies of the three (3) most recent paycheck stubs or a statement from employer(s)	☐	☐
4. Copies of three (3) most recent bank statements (e.g., savings, checking, money Market funds, IRA, 401K, etc.)	☐	☐
5. Copies of unemployment, disability compensation benefits statements	☐	☐
6. Copies of social security and/or pension benefits	☐	☐
7. Copy of Food Stamp allocation	☐	☐
8. Copies of dividend sources, trust funds and property tax statements	☐	☐
9. Copies of government assistance notices;		
Department of Health & Human Services notices (all pages)	☐	☐
Medicaid Spend Down Letters, Copies of Denial Notices from Medicaid	☐	☐
Notices from Premium Assistance Plan(s) and Marketplace Insurance(s)	☐	☐

You can receive in person assistance completing this application at the following locations:

Dartmouth-Hitchcock Medical Center	Dartmouth-Hitchcock Concord	Dartmouth-Hitchcock Manchester	Dartmouth-Hitchcock Nashua	Dartmouth-Hitchcock Keene	Alice Peck Day Memorial Hospital
One Medical Center Drive	253 Pleasant Street	100 Hitchcock Way	2300 Southwood Drive	580-590 Court Street	10 Alice Peck Day Dr.
Lebanon, NH 03756	Concord, NH 03301	Manchester, NH 03104	Nashua, NH 03063	Keene, NH 03431	Lebanon, NH 03766
Local: (603) 650-6222	(603) 229-5080	(603) 695-2692	(603) 577-4055	Local: (603) 354-5430	(603) 443-9579

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 9:00 a.m. – 4:30 p.m., Monday – Friday.

Completed applications should be returned to one of the addresses below.

Dartmouth Hitchcock Medical Center
One Medical Center Dr. PFS: Level 3 FAA
Lebanon, NH 03756
FAX: (603) 650-6142

Dartmouth-Hitchcock/Cheshire
580-590 Court St. PFS: FAA
Keene, NH 04431
FAX: (603) 354-6596

Alice Peck Day Memorial Hospital
10 Alice Peck Day Drive FAA
Lebanon, NH 03766
FAX: (603) 442-5135

Dartmouth-Hitchcock Health
Attn: PFS – Level 3 – FAA
One Medical Center Dr., Lebanon, NH 03756

Dartmouth-Hitchcock/Cheshire
Attn: PFS-FAA
580 Court St., Keene, NH 03431

Alice Peck Day Memorial Hospital
Attn: FAA
10 Alice Peck Day Dr., Lebanon, NH 03766

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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*

Home 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		Self			
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
***NAME of each household member:**	________	________	________
Name of employer:	________	________	________
<u>Gross</u> 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

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 <u>Premium</u>	$_________	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.

______________________	________	______________________	________
Applicant Signature	*Date*	*C0-Applicant Signature*	*Date*