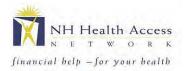
M Dartmouth-Hitchcock Health



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

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

Dartmouth-Hitchcock	Dartmouth-Hitchcock	Dartmouth-Hitchcock	Dartmouth-Hitchcock	Dartmouth-Hitchcock	Alice Peck Day
Medical Center	Concord	Manchester	Nashua	Keene	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

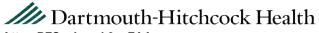
You will continue to be financially responsible for any services you receive until your completed application is received. If you have not heard from us in 30 days after returning your application, or you need help completing the application, please call one of our Patient Advocates at (844) 647-6436. 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

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

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



Attn: PFS - Level 3 - FAA

One Medical Center Dr., Lebanon, NH 03756

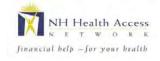
Financial Assistance Application

1. Patient's Information:

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

Last Name	First Name	Middle Initial		Soc	cial Security Num	ber	Date of Birth
Street Address		City		State	Zip (code Lengti	h of time at address
Mailing Address	6	Ci	ity	Sta	ate	Zip code	
					Single	☐ Married	☐ Civil Union
Home Phone Nu	ımber	Work I	Phone Number		☐ Separated☐ US Citizen	☐ Divorced	_
2. Person Resp	oonsible for Payi	ng the Bill					
•	•	•					
Last Name	Firs	t Name	Middle Initial	Relatio	nship to Patient	Social	Security Number
Address if Differen	ent From Patient's	3		Home Phone	e Number	Work Pho	ne Number
Name of Insuran	Name of Insurance Company Effective Date						
3. **Please ind	licate ALL peop	ole living in the	household, include	ling applicar	nt: Use	additional shee	et of paper if needed
NAME	RELA	TIONSHIP TO PA	ATIENT DATE OF	BIRTH SO	C. SECURITY#	А	pplying Yes/No
1	Se	elf .					
2							
3							
4							
5							
6							
4. Is this application	ation for future c	or past services?	?	Past Date	(s) of Services:		
Health insurance	ut if anyone in yo ce (Plan/Name)		_ , Health savings a	ccount(circle)	– Yes No	Who:	
Medicare Part A	, Medicare Par	t B Receives a	assistance to pay Med		Who:		
	-		edicaid? Yes				
			and denied please pro				
	•			∐ Yes ∐ N	No If yes, where	<u> </u>	
8. Is anyone in	your household	pregnant?] Yes □ No				
9. Has anyone	in your househo	ld served in the	military?	□No	Who:		
10. Have you re	ecently filed a wo	orkers' compens	sation or motor vehi	cle accident o	claim? Yes	□No	Date:
11. Is anyone in	n your househol	d eligible for Soc	cial Security benefits	?	No Who:		
12 Does anvor	ne else claim voi	u on their incom	e tax return?	□ Yes □ No	o Who:		

13. HOUSEHOLD INFORMATION	PERSON 1	PERSON 2	PERSON 3	
*NAME of each household me	mber:			
Name of employer:				
Gross Monthly Income From:				
Employment:	\$	\$	\$	
Self-Employment:	\$	Φ.		
Investment Accounts:	\$	•	\$	
Real Estate rentals:	\$	 \$ 	 \$	
Unemployment: (since (/_	<u>/</u>) \$	\$		
Retirement:	\$	\$	\$	
(Soc. Security, Pension, Annui Alimony/Child Support:		\$	\$	
Public Assistance, Food Stamps	<u>- </u>			
Other Income:	\$	\$	\$	
Savings and Investments:				
Checking Account Balances		\$		
Savings & CD Account Balance	s \$	\$	\$	
IRAs, 403B, 401K:		_	_	
Specify:		\$	\$	
Other savings and investments:		\$	\$	
Specify:	\$			
Outer.				
Automobile: Year, Make, Mode	1?		_	
Recreational Vehicle: Year, Make, Model	·			
	-			
14. HOUSEHOLD EXPENSES				
	М (В (А	NA (D. I	
Monthly Rent Payment: \$	or Μοπgage Payment: \$	Moπgage Loan	Balance \$	
Property Tax Amount Not Included in Paym	ant Amount Above: ¢	Value of Homes	\$	
Property Tax Amount Not included in Payin	ent Amount Above. p	value of Hoffle.	Φ	
Do You Own Property Other Than Primary I	Residence? ☐ Yes ☐ N	o If Yes. Value \$	Mortgage balance:\$	
			<u>-</u>	
If other property is a business, list address:				
Monthly Loan Payment: \$	Paid to:	For:		
Madiana Dark Daladuated fram Orbid Cons	unite calca also Di Van D	7 No. A		
Medicare Part D deducted from Social Secu	ırity check:	No Amount:\$		
Utilities \$	Insurance (Auto/Life/Prope	rty) \$ Other:	\$	
Alimony/Child Support \$	Health Insurance Premium	\$ Other:	\$	
Child Care \$	Healthcare Bills	\$ Other:	\$	
	Medications		\$	
		Ψ Other	Ψ	
15. ASSIGNMENT OF RIGHTS Read Carefully				
By signing below I authorize the request for my				
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 o				
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				
their health care or to their financial assistance members have sought health care services or				
federal regulations. Elective procedures might			ential under the provisions of the AA	
I agree that I will repay the full financial assista			ces covered by this application, for	
example insurance payments, government pro	= : : :		al forma a sa callente (19 c. 19 c.) 1	
If I receive Financial Assistance, I agree to tell changes to family size, income and health insu				
	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	