Elliot Health System

One Elliot Way
Manchester, NH 03103
603-663-7235

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*

Home Phone Number *Work Phone Number*

check one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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*	*DOB*	*SOC. SECURITY #*	*PRIMARY CARE PROVIDER*
A		**SELF**			
B					
C					
D					
E					
F					

4. Has anyone in your household applied for public assistance such as Medicaid? ☐ Yes ☐ No Who: _____

5. Has anyone in your household served in the military? ☐ Yes ☐ No Who: _____

6. Have you recently filed a worker's compensation claim? ☐ Yes ☐ No Date: _____

7. Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No Who: _____

8. Is anyone in your household covered by health insurance? ☐ Yes ☐ No Who: _____

Name of insurance company _____

9. HOUSEHOLD INFORMATION

	PERSON1	PERSON 2	PERSON 3
*NAME of each household member:	$ _____	$ _____	$ _____
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	$ _____	$ _____	$ _____
Other savings and investments:	$ _____	$ _____	$ _____
Specify: _____	$ _____	$ _____	$ _____
Other:			
Value of Automobile:	$ _____	$ _____	$ _____
What is the Year, Make, Model?	$ _____	$ _____	$ _____
Value of Recreation Vehicle?	$ _____	$ _____	$ _____
What is the Year, Make, Model?	$ _____	$ _____	$ _____

10. 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, What is the Value? $_____
Monthly Loan Payment: $_____Paid to: _____For: _____
Monthly Loan Payment: $_____Paid to: _____For _____

Utilities	$ _____	Insurance (Auto/Life/Property)	$ _____	Other_____	$ _____
Alimony/Child Support	$ _____	Health Insurance	$ _____	Other_____	$ _____
Child Care	$ _____	Healthcare bills	$ _____	Other_____	$ _____
Living (gas, food, cloths)	$ _____	Medications	$ _____	Other_____	$ _____

11. OTHER COMMENTS

☐ Check here if you have attached information you would like considered with your application.

12. 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.

By signing below, I certify that all information I have submitted is true, I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

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 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.

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 programs 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 change 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/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

Signature Date Signature Date