FINANCIAL ASSISTANCE APPLICATION

Financial Assistance
PO Box 678, Laconia, NH 03247
Tel: 603-527-7171 Fax: 603-527-7038

Have you exhausted all opportunity for coverage by applying for health insurance?

YES **NO** (please circle one)

1. Patient Information

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Physical Address		City	State	Zip Code
Mailing Address		City	State	Zip Code

Home Phone Number | Work Phone Number | Dates at this address: (If less than 18 Months) list address:

Check One: ☐Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Are you a Citizen? ☐Yes ☐ No

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 necessary

	Name	Relationship to Patient	Date of Birth	Social Security #	Name of Physician
1	self				
2					
3					
4					

4. Is this application for ☐ Future or ☐ Past Service? Date(s) of Services: ______________________

5. Has anyone in your household applied for NH Healthy Kids or Medicaid? ☐ Yes ☐ No

Who: ______________ When? __________ What is the status ☐ Pending ☐ Denied Reason:__________

6. Has anyone in your household served in the military? ☐ Yes ☐ No Who: ______________________

7. Have you recently filed a worker's compensation claim? ☐ Yes ☐No Date: ____________ Settled __________

8. Pending approval for any type of disability? ☐ Yes ☐ No What type ______________________

9. Do you have a liability suit or law suit pending? ☐ Yes ☐ No If yes, explain: ______________________

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

11. Name of Employer ______________________________________

12. Have you or anyone in your household had access to health insurance in the past three months? ☐ Yes ☐ No

If yes, did the cost of this insurance increase in the past three months? ☐ Yes ☐ No

Name of Insurance Company ______________________________ Expiration Date: __________

13. Household Information

	Person 1	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 and CD Account Balances	$	$	$
IRAs, 403B, 401K, etc. Specify: ___________________________	$	$	$
Other Savings and Investments Specify: ___________________________	$	$	$
Other: Ownership of real estate by legal, equitable or beneficial means. *			
Value of Home *	$	$	$
Value of Automobile	$	$	$
What is the Year, Make, Model	$	$	$
Value of Recreation Vehicle (boat, jet ski, ATV, Snowmobile, Camper, etc)	$	$	$

Year, Make, Model: ______________________________

14. Household Expenses

Mortgage/Rent	Monthly	Utilities	Monthly	Necessities:	Monthly
** Home		Oil/Gas		Groceries	
**Apartment		Wood		Child Support	
Lot/Land		Other Heat		Other:	
**Property Taxes		Water & Sewer		Gas/Auto #1	
Medical Expenses		Electricity		Gas/Auto #2	
Physician/Providers		**Personal Vehicle**		Telephone	
Pharmaceutical		Auto #1		Cable	
		Auto #2		Child Care	
		Insurances:		Incidentals	
		Medical/Health		**Charge Cards**	
LRGH		Auto #1			
Other Medical:		Auto#2			
		Home Owners/Rental			

15. Assignment of Rights Please 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 proves 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 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 provision sof HIPAA federal regulations. Elective procedures may not be considered for assistance. I agree that I will repay the full financial assistance awarded 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 medial 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 Date Co-applicant Signature Date