

Dear Applicant:

You may be able to get financial help from Cottage Hospital and possibly other healthcare organizations.

The NH Health Access Network is a group of hospitals, doctors and other health care providers in New Hampshire that work together to help children and adults when they cannot afford the health care they need.

*The NH Health Access Network is for individuals who have insurance.* To get financial help through the NH Health Access Network with out-of-pocket expenses your insurance must be active and accepted by and in-network with the provider. (Medicaid Spend Down Program is not insurance so those eligible for or enrolled in this program are not eligible for the NH Health Access Network.) If you have no insurance, financial assistance *may* be available from your provider; for more information, please contact our financial counselor at 603-747-9220.

Documentation	Attached	Not Required
Complete copy of your most recent Federal Income Tax Return and all schedules		
Copies of most recent W-2 forms		
Copies of the three (3) most recent, consecutive paycheck stubs or a statement from the employer.		
Copies of the three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) <b>ALL PAGES</b>		
Copies of unemployment or disability compensation benefits statements		
Copies of pension benefits stubs		
Copies of social security income (yearly benefits statements, copy of check or direct deposit)		
Copy of Food Stamp allocation		
Copies of government assistance notices (including Department of Health & Human Services and Medicaid Spend Down Letter)		
Copies of Denial Notices from Medicaid, including Premium Assistance Plan		

Copies of financial subsidies notices from Marketplace		
--	--	--

Please use this checklist to be sure we have all the information we need to quickly and correctly process your application. We may ask you for additional information about your credit evaluation and income tax return. The information you provide is confidential.

You will continue to be financially responsible for any services you receive until we know whether you qualify for help. If you have not heard from us in 60 days after returning your application, or you need help in understanding it, please call 603-747-9220 at Cottage Hospital.

Sincerely

**PLEASE RETURN THE APPLICATION AND REQUESTED DOCUMENTS TO COTTAGE HOSPITAL**

**Financial Assistance Application**

**1. Patient's Information:**

<i>Last Name</i>		<i>First Name</i>		<i>Middle Initial</i>	
<i>Social Security Number</i>			<i>Date of Birth</i>		
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>Zip code</i>	<i>Length of time at address</i>
<i>Mailing Address</i>		<i>City</i>	<i>State</i>	<i>Zip code</i>	
<i>Home Phone Number</i>		<i>Work Phone Number</i>		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> US Citizen <input type="checkbox"/> NH Resident	

**2. Person Responsible for Paying the Bill**

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Relationship to Patient</i>	<i>Social Security Number</i>
<i>Address if Different From Patient's</i>		<i>Home Phone Number</i>		<i>Work Phone Number</i>
<i>Name of Insurance Company</i>				<i>Effective Date</i>

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

<i>NAME</i>	<i>RELATIONSHIP TO PATIENT</i>	<i>DATE OF BIRTH</i>	<i>SOC. SECURITY#</i>	<i>Applying Yes/No</i>
1	<b>Self</b>			

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:** \_\_\_\_\_

**Gross Monthly Income From:**  
**Employment** \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Self Employment** \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Investment Accounts** \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Real Estate Renters** \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Unemployment**  
**(Since \_\_\_\_\_)** \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Retirement**  
**Soc Security/Pension/annuity** \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_



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*