



Dear Patient,

You may be eligible for financial assistance from Alice Peck Day Memorial Hospital and possibly other NH Health Access Network providers.

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 can't afford the health care they need.

To get financial help through the NH Health Access Network, you must have tried to get, and been refused, all other sources of payment including insurance, public assistance, or a lawsuit.

To find out if you or your household qualifies, you must give us proof of your income. Please fill out the attached application and sign it. Then, please send us that application and a COPY of each of the following for your household: **Please note that if any of the below pertains to your financial information and is not received in whole it will result in an incomplete letter being sent to you and will hold up your application process.**

1. Complete copy of your most recent Federal Income Tax Return and all schedules.
2. Last year's W-2 forms
3. Copies of the three (3) most recent, consecutive paycheck stubs or a statement from the employer
4. Complete copies of three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) **THIS INCLUDES ALL PAGES OF YOUR BANK STATEMENTS AND CHECK COPIES.**
5. Copies of unemployment or disability compensation benefits statements
6. Copies of pension benefits stubs
7. Copies of social security income (yearly benefits statements, copy of check or direct deposit)
8. Copy of Food Stamp allocation
9. Copies of government assistance notices (including Department of Health & Human Services)



ALICE PECK DAY MEMORIAL HOSPITAL



Please use the above checklist to confirm that all required information is included 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 have learned whether you qualify for help.

If you have not heard from us in 30 days after returning your application, or you need help in understanding it, please call Patient Access at (603) 448-3121.

Sincerely,

Patient Access  
Alice Peck Day Health Systems  
603-448-3121



Financial Assistance: Checklist

Please make sure that you have answered all the questions on the application and included copies of documents that apply to you.

\_\_\_\_\_ Did you sign page 2 of the application?

\_\_\_\_\_ Did you enclose a complete copy of your most recent Federal tax return and W2 forms? (The tax return is the form you fill out and send to the IRS – The W2 is the form your employer provides you with)

\_\_\_\_\_ Did you enclose copies of 3 recent pay stubs?

\_\_\_\_\_ Did you enclose copies of bank statements for the last 3 months?

\_\_\_\_\_ If you own other property in addition to your primary residence. Please include the property tax receipt.

If you are currently unemployed, what was your last day of work? \_\_\_\_\_

If you are temporarily out of work, do you expect to return to the same job?

\_\_\_\_\_ Yes      \_\_\_\_\_ No      If so, when? \_\_\_\_\_

If you did not enclose a copy of last year's tax return, please indicate reason why:

\_\_\_\_\_ Do not have to file – retired

\_\_\_\_\_ Did not make enough money to file

\_\_\_\_\_ Did not keep a copy of last year's tax return.

What monthly payment would you be able to make toward your Hospital bill? \$ \_\_\_\_\_

What monthly payment would you be able to make toward your clinic bill? \$ \_\_\_\_\_



Financial Assistance Application

1. Patient's Information:

Form fields for Patient's Information: Last Name, First Name, Middle Initial, Social Security Number, Date of Birth, Street Address, City, State, Zip code, Mailing Address, Home Phone Number, Work Phone Number, and marital status options (Single, Married, Civil Union, Separated, Divorced, Widowed).

2. Person Responsible for Paying the Bill

Form fields for 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

Table with 5 columns: NAME, RELATIONSHIP TO PATIENT, DATE OF BIRTH, SOC. SECURITY#, DOCTOR'S NAME. Row 1 contains 'Self'.

- 4. Is this application for future or past services?
5. Has anyone in your household applied for NH Healthy Kids or Medicaid?
6. Have you applied for financial assistance at another facility?
7. Is anyone in your household pregnant?
8. Has anyone in your household served in the military?
9. Have you recently filed a workers' compensation or motor vehicle accident claim?
10. Is anyone in your household eligible for Social Security benefits?
11. Is anyone in your household covered by health insurance, Medicare or a health savings account (HSA)?
12. Does anyone else claim you on their income tax return?

13. HOUSEHOLD INFORMATION	PERSON 1	PERSON 2	PERSON 3
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\*NAME of each household member: \_\_\_\_\_

Name of employer: \_\_\_\_\_

**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
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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	\$ _____	Other: _____	\$ _____
Child Care	\$ _____	Healthcare Bills	\$ _____	Other: _____	\$ _____
Living (gas, food, clothes)	\$ _____	Medications	\$ _____	Other: _____	\$ _____

15. ASSIGNMENT OF RIGHTS <i>Read Carefully</i>
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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 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 may 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	CO-Applicant Signature	Date
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