FINANCIAL ASSISTANCE APPLICATION

LRGHealthcare care. compassion. community.

HEALTHLINK

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1 Patient Information

Las	t Name	First Name	Middle Initial	Social Security Numb	er Date of Birth			
 Phy	vsical Address		City	State	Zip Code			
Ma	iling address		City	State	Zip Code			
Ho	me Phone Number	Work Pi	hone Number Dat	es at this address: (If less to	han 18 months) list address:			
Ch	eck One: Single	☐ Married ☐ Se	eparated Divorced	☐ Widowed Are you	u a Citizen? 🗌 Yes 📗 No			
2. F	Person Responsibl	e for Paying the B	Bill					
Las	t Name	First Name	Middle Initial R	Pelationship to Patient	Social Security Number			
Add	dress if Different from	Patient's	Home Phone Nu	ımber Work	Phone Number			
Naı	me of Insurance Com	pany		Effective Date				
3. 1	State Zip Code							
2								
3								
4								
4.	Is this application f	or Future or	Past services? Date(s) of Services:				
5.	Has anyone in your household applied for NH Healthy Kids or Medicaid? Yes No							
	Who:	When?	What is the stat	us? Pending Denie	d Reason:			
6.								
7.	Address if Different from Patient's							
8.	<u> </u>							
9.								
10.	Is anyone in your h	ousehold eligible fo	or Social Security bene	fits?	0:			
11.	Name of employer							
	Has you or anyone	in your household	had access to health in	nsurance in the past three	e months? Yes No			
		-		•				
	Name of Insurance	Company	·	Expira	ation 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 & CD Account Balances	\$	\$	\$
IRAs, 403B, 401K:			
Specify:	\$	\$	\$
Other savings and Investments:			
Specify:	\$	\$	\$
Other: Ownership of real estate by legal, ed	quitable or beneficial	means.*	
Value of Home*	\$		
Value of Automobile:	\$	\$	\$
What is the Year, Make, Model?			
Value of Recreation Vehicle:			
(Boat, Jet Ski, ATV, Snowmobile, etc.)	\$	\$	\$
What is the 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	
Physicians/Providers		Personal Vehicles:		Telephone	
		Auto #1		Cable	
		Auto #2		Child Care	
Pharmaceutical		Insurances:		Incidentals	
LRGH		Medical/Health		Charge Cards:	
Other Medical:		Auto#1			
		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 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.