

FINANCIAL ASSISTANCE APPLICATION

LRGHealthcare

care. compassion. community.

HEALTHLINK

PO Box 1327, Laconia, NH 03247

Tel: 603-527-7171 Fax: 603 934 4583

Have you exhausted all opportunities for coverage by applying for health insurance?
YES NO (please circle one)



1. Patient Information

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Social Security Number</i>	<i>Date of Birth</i>
<i>Physical Address</i>		<i>City</i>	<i>State</i>	<i>Zip Code</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>	<i>Dates at this address: (If less than 18 months) list address:</i>		
Check One: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Are you a Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No				

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>	

3. 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>Social Security #</i>	<i>Name of Physician</i>
1 Self				
2				
3				
4				

- Is this application for Future or Past services? Date(s) of Services: _____
- Has anyone in your household applied for NH Healthy Kids or Medicaid? Yes No
 Who: _____ When? _____ What is the status? Pending Denied Reason: _____
- Has anyone in your household served in the military? Yes No Who: _____
- Have you recently filed a workers' compensation claim? Yes No Date: _____ Settled _____
- Pending approval for any type of disability? What type _____
- Do you have a liability suit or law suit pending? Yes No If yes explain: _____
- Is anyone in your household eligible for Social Security benefits? Yes No Who: _____
- Name of employer _____
- Has you or anyone in your household had access to health insurance in the past three months? Yes No
 If yes, did the cost for this health 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 & CD Account Balances	\$ _____	\$ _____	\$ _____
IRAs, 403B, 401K:			
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, 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.

Applicant Signature

Date

Co-applicant Signature

Date