CONCORD HOSPITAL

Financial Assistance

250 Pleasant Street Concord, NH 03301
(603)227-7101 or toll-free: 1(800)562-1542
TTY/TTD: (603)230-7455 or TTY/TTD toll-free: 1(888)833-4408
concordhospital.org
Email: financialcounseling@crhc.org
Fax: 603-227-7104

Dear Applicant:

To submit an application for financial assistance through Concord Hospital, you must provide the following documents that apply:

Required	N/A	
☐	☐	**Complete both sides of the application and sign the bottom**
☐	☐	**A copy of your complete, current Federal Income Tax Return with all schedules, or a signed statement of non-filing (box on application)**
☐	☐	**Copies of your 3 most recent, consecutive paycheck stubs or a statement from the employer**
☐	☐	**Copy of your most recent bank statements (savings, checking, money market, IRA, 401K, etc.)**
☐	☐	**Copy of unemployment or disability compensation benefits statements**
☐	☐	**Copy of pension benefits stubs**
☐	☐	**Copy of social security income (yearly benefits statements, copy of check or direct deposit)**
☐	☐	**Copy of Department of Health & Human Services decision letters (Medicaid, Food Stamps, etc.)**

The information you provide is confidential. If you would like your documents returned to you, please provide a self-addressed envelope.

You will continue to be financially responsible for any services you receive until we have determined whether you qualify for assistance. We encourage you not to discontinue care while your application is being processed.

If you need assistance with your prescriptions, please call the Prescription Assistance department for an application at 227-7009.

Financial Assistance will not apply to any account(s) that have been sent to a collection agency. It also does not cover services rendered by outside entities. Financial Assistance is not available for prescription drugs, cosmetic procedures, complementary medical services, outpatient preventive dental services unless provided at Concord Hospital Family Health Center Dental Clinic, investigational services, or elective non-covered services as specified by Medicare and other third party coverage guidelines. Concord Hospital reserves the right to determine if a service will be considered under Financial Assistance.

Sincerely,
Concord Hospital

Financial Assistance Application

***If you would like your supporting documents returned to you, please provide a self-addressed envelope.**

1. Patient's Information:				
Last Name	First Name	MI	Social Security Number	Date of Birth
Street Address	City		State	Zip Code
Mailing Address ☐ same as above	City		State	Zip Code
Phone Number	Alternate Phone	Primary Care Physician		
☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed

2. Person responsible for paying the bill:	☐ **Same as the Patient**			
Last Name	First Name	MI	Social Security Number	Date of Birth
Address (if different from patient's)	City		State	Zip Code
Phone Number	Alternate Phone	Relationship to Patient		

3. Indicate all people living in the household: **Use additional sheet of paper if needed.*

Name	Relationship	Social Security No	Date of Birth	Insurance Plan
Same as the Patient	Self	See Above	See Above	

4. Are you applying for past or future services?	☐ **Past** ☐ ***Future**			
∗ **Please describe future services needed:**				
5. Name anyone in your household that is pregnant:				
6. Name anyone in your household that recently applied for Medicaid:				
7. Does anyone else claim you on their income tax return?	☐ **No**	☐ ***Yes**	**Who?**	

8. Gross Monthly Income Information (before taxes) for each member of the household			
	Person 1	Person 2	Person 3
Name of Household Member:			
Name of Employer:			
Employment:	$	$	$
Self-Employment:	$	$	$
Unemployment:	$ Date	$ Date	$ Date
Social Security:	$	$	$
Pension:	$	$	$
Annuities:	$	$	$
Alimony/Child Support:	$	$	$
Public Assistance:	$	$	$
Real Estate Rental Income:	$	$	$
No Income	☐	☐	☐

9. Financial Account Balances (most recent) *Please list all accounts for each member of household.			
	Person 1	Person 2	Person 3
Checking Account:	$	$	$
Savings Account:	$	$	$
Retirement Account: (IRA, 403b, 401K or CDs)	$	$	$
No Bank Accounts	☐	☐	☐

10. Monthly Expenses					
Rent Payment:	$	Mortgage Payment of Primary Residence:	$		
Do you own other property other than your primary residence?	☐ No ☐ *Yes				
*Value of other property:	$	*Mortgage Balance on other property:	$		
*If other property is a business, list address:					
Are Medicare Part B or Part D payments deducted from your Social Security check?	☐ No ☐*Yes	*Amount:	$		
Alimony/Child Support:	$				

☐ ***By checking this box, I attest that I/we did not file taxes last year.***

11. Recent changes to your finances (ex: out of work, unexpected injury)

Financial Assistance is available for medically necessary services only. Financial Assistance will not apply to any account(s) that have been assigned to a collection agency.

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. In the event that I have not fully disclosed, or have inaccurately represented, any income or assets; any agreement to provide you with a charitable care discount would be null and void and would be retroactive back to the date the bills were owed. I may be liable for any/all legal fees during the collection process.

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 might 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 _____