LRGHealthcare
care. compassion. community.

HEALTHLINK
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FINANCIAL ASSISTANCE APPLICATION

1. Patient Information

Last Name | *First Name* | *Middle Initial* | *Social Security Number* | *Date of Birth*

Physical Address | *City* | *State* | *Zip code*

Mailing address | *City* | *State* | *Zip code*

check one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Phone Number | *Work Phone Number*

Are you a Citizen? ( ) Yes ( ) No

Dates at this address: *(If less than 18 months) list address:*

2. 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

	NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOC. SECURITY#	NAME OF PHYSICIAN
1		Self			
2					
3					
4					
5					
6					

4. Is this application for future or past services? ☐ Future ☐ Past Date(s) of Services:___________________________

5. Has anyone in your household applied for NH Healthy Kids or Medicaid? ☐ Yes ☐ No Who:_____________________

When?_______________ What is the status? ☐ Pending ☐ Denied Reason:____________________________________

6. Has anyone in your household served in the military? ☐ Yes ☐ No Who:_________________________________

7. Have you recently filed a workers' compensation claim? ☐ Yes ☐ No Date:_____________Settled_____________

8. Pending approval for any type of disability? What type____

9. Do you have a liability suit or law suit pending? ( ) Yes ( ) No If yes explain:__________________________

10. Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No Who:___________________________

11. Name of employer ____

12. Have you or anyone in your household had access to health insurance in the past three months? ( ) Yes ( ) No

If yes, did the cost share 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

Mortage/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			
		Aurto#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***