

## **Financial Assistance Application**

| Date: | Account No (s): |  |  |  |
|-------|-----------------|--|--|--|
|       |                 |  |  |  |
| Dear: |                 |  |  |  |

If payment of your health care expenses could create a financial hardship for you, please fill out this application. This application will help us to determine our ability to reduce those expenses for services provided by Core Physicians. Financial assistance will apply only to services incurred on or after January 1, 2008. Please answer all questions that apply to you or your household. Any information you provide is confidential and is reviewed only by the staff processing your application.

Before any financial assistance is granted, you must have already exhausted all other sources of payment including insurance, public assistance, litigation, or third-party liability. The completed application and documentation must be returned to our office within 45 days. We cannot process your application without the required supporting documentation. The required supporting documentation must be provided within 45 days of the application or the application will be considered closed.

Please use this checklist to insure that all required information is submitted, to quickly and correctly process your application. We reserve the right to request additional information, if necessary. All information provided is confidential.

- 1. Completed application with signatures.
- 2. A complete and <u>signed</u> copy of your 2009 Federal Income Tax Return, including all schedules and W-2 forms.
- 3. Copies of the three (3) most recent consecutive paycheck stubs or a statement from the employer, from each household member.
- 4. Copies of three (3) most recent consecutive bank statements (e.g., savings, checking, money market, IRA, 401K, etc.), **all pages**, for all accounts.
- 5. Copies of unemployment, disability compensation benefits statements.
- 6. Copies of social security and/or pension benefits income.
- 7. Copy of Food Stamp allocation.
- 8. Copies of government assistance notices (including Department of Health & Human Services).

You will continue to be financially responsible for any services you receive until eligibility is determined. If you have not heard from us in 30 days after returning your application, or you need help in understanding it, please call our Financial Assistance Office at (603)580-7232.

Sincerely,

Financial Assistance Office Core Physicians P.O. Box 655 7 Holland Way Exeter, NH 03833 **Financial Assistance Application** Page 1 of 2 1. Patient's Information: Last Name First Name Middle Initial Social Security Number Date of Birth Street Address City State Zip Code Mailing Address State Zip Code City Home Phone Number Work Phone Number Check one: Single Married Separated Divorced \_ Widowed 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 Policy Number Effective Date 3. Please indicate ALL people living in the household, including applicant: Use additional sheet of paper if needed 4. Is this application for future or past services? \_\_\_Future Past Date(s) of Services:\_ 5. Has anyone in your household applied for Financial Assistance through Exeter Hospital? Yes \_\_No Who:\_\_\_ What is the status? \_\_\_Pending \_Denied Reason: 6. Has anyone in your household applied for Finanacial Assistance through Core General Dentistry? Yes \_\_\_\_ Who\_ \_\_Yes \_\_\_\_No 7. Has anyone in your household applied for NH Healthy Kids or Medicaid? Who:\_\_\_\_ What is the status? \_\_\_Pending Reason:\_ 8. Is anyone in your household pregnant? Yes No 9. Are you a United States Citizen? Yes No 10. Has anyone in your household served in the military? Who:\_ \_\_\_Yes \_\_No 11. Have you recently filed a workers' compensation or motor vehicle accident claim? \_\_\_Yes \_\_No Date:\_\_\_ 12. Is anyone in your household eligible for Social Security Benefits? Yes No Who: \_Yes \_\_\_No Who:\_\_ 13. Is anyone in your household covered by health insurance or a health savings account (HSA)? 14. Does anyone else claim you on their income tax return? Who:

Yes

No

| 13. HOUS  | SEHOLD INFORMATION     | ON                | PERSON 1  |                     | PERSON 2                      | PERSO | N 3 |  |
|---|------------------------|-------------------|---|---------------------|-------------------------------|-------|-----|--|
|   | Name of each housel    | hold member:      |   |                     |                               |       |     |  |
|   | Name of employer:      |                   |   |                     |                               |       |     |  |
| Monthly Income from:  |                        |                   |   |                     |                               |       |     |  |
| ,   | Employment:            |                   | \$  | \$                  |                               | \$    |     |  |
|   | Self Employment:       |                   | \$  |                     |                               | \$    |     |  |
|   | Investment Accounts:   |                   | \$  |                     |                               | \$    |     |  |
|   | Real Estate Rentals:   |                   | \$  |                     |                               | \$    |     |  |
|   | Unemployment: (sind    | ce/)              | \$  | \$                  |                               | \$    |     |  |
|   | Retirement:            |                   | \$  | \$                  |                               | \$    |     |  |
|   | (Soc. Security, Pensi  | ion, Annuity)     |   |                     |                               |       |     |  |
|   | Alimony/Child Suppor   | rt:               | \$  | \$                  |                               | \$    |     |  |
|   | Public Assistance,Foo  | od Stamps:        | \$  | \$                  |                               | \$    |     |  |
|   | Other Income:          |                   | \$  | \$                  |                               | \$    |     |  |
| Savings and Investments:  |                        |                   |   |                     |                               |       |     |  |
| •   | Checking Account Ba    | lances            | \$  | \$                  |                               | \$    |     |  |
|   | Savings & CD Accoun    | nts Balances      | \$  | \$                  |                               | \$    |     |  |
|   | IRA's, 403B, 401K:     |                   |   |                     |                               |       |     |  |
|   | Specify:               |                   | \$  | \$                  |                               | \$    |     |  |
|   | Other savings and inv  | vestments:        |   |                     |                               |       |     |  |
|   | Specify:               |                   | \$  | \$                  |                               | \$    |     |  |
|   |                        |                   |   |                     |                               |       |     |  |
| Other:  |                        |                   |   |                     |                               |       |     |  |
|   | Value of Automobile:   |                   | \$  | \$                  |                               | \$    |     |  |
|   | What is the Year,      | Make, Model?      |   |                     |                               |       |     |  |
|   | Value of Recreation \  |                   | \$  | \$                  |                               | \$    |     |  |
|   | What is the Year,      | Make, Model?      |   |                     |                               | -     |     |  |
| 14. HOUS  | SEHOLD EXPENSES        |                   |   |                     |                               |       |     |  |
| Monthly R   | tent Payment: \$       |                   | or Mortgage Payment \$                            |                     | Mortgage Loan Balance         | \$    |     |  |
| Property 1  | Fax Amount Not Include | ed in Payment Amo | unt Ahove: \$                                     | ,                   | Value of Home: \$             |       |     |  |
| Property Tax Amount Not Included in Payment Amount Above: \$  |                        |                   |   |                     |                               |       |     |  |
| Do You Own Property Other Than Primary Residence?YesNo If Yes, What is the Value? \$  |                        |                   |   |                     |                               |       |     |  |
| Monthly Loan Payment: \$ Paid to: For:  |                        |                   |   |                     |                               |       |     |  |
| Medicare Part D deducted from Social Security check:YesNo Amount: \$  |                        |                   |   |                     |                               |       |     |  |
| Utilities   |                        | \$                | Insurance (Auto/Life/Property)                    | \$                  | Other: _                      |       | \$  |  |
| Alimony   |                        | \$                | Health Insurance                                  | \$                  | Other: _                      |       | \$  |  |
| Child Care  | е                      | \$                | Healthcare Bills                                  | \$                  | Other: _                      |       | \$  |  |
| Living (ga  | s, food, clothes)      | \$                | Medications                                       | \$                  | Other: _                      |       | \$  |  |
| 15. Assig   | gnment of Rights       | Read Carefully    |   |                     |                               |       |     |  |
|   |                        | •                 | or tay return. Lunderstand that a tay return in a | eeded to presses th | nic application and that mare |       |     |  |
| 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 have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. |                        |                   |   |                     |                               |       |     |  |
| I agree that I will repay in full the 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 Core Physicians, LLC 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 Sig   | gnature                |                   | Date  | Co-Applicant S      | ignature                      | Date  |     |  |
|   |                        |                   | ****  |                     | -                             |       |     |  |