



80 Highland Street Laconia, NH 03246 (603) 524-3211
 concordhospital-laconia.org



15 Aiken Avenue Franklin, NH 03235 (603) 934-2060
 concordhospital-franklin.org

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 <input type="checkbox"/> same as above		City	State	Zip Code
Phone Number	Alternate Phone	Primary Care Physician		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed

2. Person responsible for paying the bill:		<input type="checkbox"/> 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:				<i>*Use additional sheet of paper if needed.</i>
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?	<input type="checkbox"/> Past	<input type="checkbox"/> *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?	<input type="checkbox"/> No	<input type="checkbox"/> *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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Monthly Expenses			
Rent Payment:	\$	Mortgage Payment of Primary Residence:	\$
Do you own other property other than your primary residence?		<input type="checkbox"/> No <input type="checkbox"/> *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?		<input type="checkbox"/> No <input type="checkbox"/> *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