



Dear Patient:

If payment of your health care expenses could create a financial hardship for you, please complete the attached application. This application will help us determine if you are eligible for financial assistance at Androscoggin Valley Hospital (AVH) and/or Androscoggin Valley Surgical Associates (ASA). **To be eligible for the AVH/ASA program, you must live in Coos County. Any information you provide is confidential.**

You may also be eligible for financial assistance with other participating providers of the NH Health Access Network if the criteria is met. The NH Health Access Network (NHHAN) is a network of hospitals, doctors and other health care providers that work to improve access to health care for uninsured or under-insured *residents of the State of New Hampshire.*

Before any financial assistance can be granted, **you must have already exhausted all other sources of payment, including insurance, medical savings accounts, public assistance, Medicaid deductibles or a lawsuit.** Please use the check list below to be sure you have included all the necessary information needed to process your application.

- 1. Completed application signed by patient(s)
- 2. **Complete** copy of your most recent Federal Income Tax Return WITH ALL schedules AND W-2's.
- 3. Copy of the four (4) most recent consecutive paycheck stubs or a statement from your employer showing the total gross income for one month.
- 4. Copy of the three (3) most recent bank statements (i.e. savings, checking, money market, IRA, 401K, etc.) or copy of savings passbook showing three months current transactions.
- 5. Copy of unemployment, workers compensation or disability compensation benefit statements
- 6. Copy of annual social security, Veteran of Foreign Affairs (VA) or pension explanation of benefits letter.
- 7. Copy of any government (state, local, federal) assistance or denial notice for food stamps, medical coverage, rental, etc.
- 8. **For property owners:** Copy of current property tax bill showing the assessed value of the property AND a copy of a mortgage statement showing the current mortgage or home equity balance.

**We reserve the right to request additional information.** You will continue to be financially responsible for any services you receive until eligibility is determined. If you have not received a determination within thirty (30) days after returning your complete application, or if you need help completing this, please contact the Customer Service Department at 603-326-5653 or 603-326-5660.

Completed applications should be returned to: Androscoggin Valley Hospital, Attention: Customer Service, 59 Page Hill Road, Berlin, NH 03570.

***Incomplete applications delivered in person to the Customer Service Department will not be accepted. Incomplete applications not delivered to the Customer Service Department in person will automatically be denied in writing.***

## Financial Assistance Application

### 1. Patient's Information:

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

*Street Address*                      *City*                      *State*                      *Zip code*

*Mailing Address*                      *City*                      *State*                      *Zip code*

Single                       Married                       Civil Union

*Home Phone Number*                      *Work Phone Number*                       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*                      *Effective Date*

### 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>SOC. SECURITY#</i>	<i>DOCTOR'S NAME</i>
1	<b>Self</b>			
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: \_\_\_\_\_

6. Have you applied for financial assistance at another facility?     Yes     No    If yes, where: \_\_\_\_\_

7. Is anyone in your household pregnant?     Yes     No

8. Has anyone in your household served in the military?     Yes     No    Who: \_\_\_\_\_

9. Have you recently filed a workers' compensation or motor vehicle accident claim?     Yes     No    Date: \_\_\_\_\_

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

11. Please check if anyone in your household is covered by health insurance\_\_\_\_\_, health savings account\_\_\_\_\_, Medicare Part A\_\_\_\_\_, Medicare Part B\_\_\_\_\_ Receives assistance to pay Medicare Part B\_\_\_\_\_ Who: \_\_\_\_\_

12. Does anyone else claim you on their income tax return?     Yes     No    Who: \_\_\_\_\_

13. HOUSEHOLD INFORMATION	PERSON 1	PERSON 2	PERSON 3
---------------------------	----------	----------	----------

\*NAME of each household member: \_\_\_\_\_

Name of employer: \_\_\_\_\_

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: \_\_\_\_\_

Automobile: Year, Make, Model? \_\_\_\_\_

Recreational Vehicle: Year, Make, Model? \_\_\_\_\_

14. HOUSEHOLD EXPENSES
------------------------

Monthly Rent Payment: \$ \_\_\_\_\_ or Mortgage Payment: \$ \_\_\_\_\_ Mortgage Loan Balance \$ \_\_\_\_\_

Property Tax Amount Not Included in Payment Amount Above: \$ \_\_\_\_\_ Value of Home: \$ \_\_\_\_\_

Do You Own Property Other Than Primary Residence?  Yes  No If Yes, Value \$ \_\_\_\_\_ Mortgage balance: \$ \_\_\_\_\_

If other property is a business, list address: \_\_\_\_\_

Monthly Loan Payment: \$ \_\_\_\_\_ Paid to: \_\_\_\_\_ For: \_\_\_\_\_

Medicare Part D deducted from Social Security check:  Yes  No Amount: \$ \_\_\_\_\_

Utilities \$ \_\_\_\_\_ Insurance (Auto/Life/Property) \$ \_\_\_\_\_ Other: \_\_\_\_\_ \$ \_\_\_\_\_

Alimony/Child Support \$ \_\_\_\_\_ Health Insurance \$ \_\_\_\_\_ Other: \_\_\_\_\_ \$ \_\_\_\_\_

Child Care \$ \_\_\_\_\_ Healthcare Bills \$ \_\_\_\_\_ Other: \_\_\_\_\_ \$ \_\_\_\_\_

Living (gas, food, clothes) \$ \_\_\_\_\_ Medications \$ \_\_\_\_\_ Other: \_\_\_\_\_ \$ \_\_\_\_\_

15. ASSIGNMENT OF RIGHTS <i>Read Carefully</i>
--

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

## APPLICATION ADDENDUM

PLEASE ANSWER THE FOLLOWING QUESTIONS TO ASSIST US IN MAKING A DETERMINATION  
ON YOUR APPLICATION

If the question does not pertain please answer N/A:

If you are currently unemployed, when was your last day of work? \_\_\_\_\_

Are you eligible for unemployment compensation? \_\_\_\_\_

If you are temporarily out of work, do you expect to return to the same job? \_\_\_\_\_

If so, when? \_\_\_\_\_

If you did not enclose a copy of last year's tax return, please indicate the reason why:

\_\_\_ Do not have to file - retired

\_\_\_ Did not make enough money to file

\_\_\_ Did not keep a copy of last year's tax return - *Please contact us at 326-5653 to request a transcript of tax return form.*

***Incomplete applications delivered in person to the Customer Service Department will not be accepted.  
Incomplete applications not delivered to the Customer Service Department in person will automatically be denied in writing.***

## Excluded Procedures/Services/Supplies for Reduced Charges

*The following is a partial list of excluded procedures/services/supplies and does not encompass every non medically necessary procedure/ service/supplies that would qualify as an exclusion for reduced fees.*

1. Acupuncture.
2. Artificial insemination, in-vitro fertilization, and intra-uterine implantation procedures.
3. Biofeedback.
4. Cosmetic procedures/services (physician services and related hospitalization), including charges for plastic and cosmetic surgery, botox injections, etc.
5. Dental services except bone impacted teeth.
6. **Direct admits to:** Intermediate Care (ICF), custodial care, or rest cures in AVH-ICF swing beds.
7. Experimental/Investigational procedures.
8. Insurance company claims denied for lack of referral/pre-certification that the patient is required to obtain or for patient failure to submit information being required by the insurance company.
9. Occupational Health Services.
10. Physical exams and related services for work or insurance purposes or as required for other administrative or liability reasons.
11. Private rooms.
12. Services or procedures available through federal, state or local law, regulations or programs.
13. Services or procedures for any condition, disease or injury arising out of or in the course of employment, when the member has the opportunity to be covered by a Workers' Compensation Program.
14. Services or procedures for disease or injury sustained as a result of war, riot or civil disobedience.
15. Services or procedures as a result of any accident which is covered by any liability insurance or pending outcome of settlement in a legal claim.
16. Sex transformation procedures and related services.
17. Sterilization and/or reversal of voluntary sterilization charges. Physician consultation charges for discussion of possible sterilization will be covered.
18. **Supplies, including but not limited to:** hearing aid(s), custom or other earplugs, pro plugs, swimming headband, allergy serum, IUD, other birth control devices, cast cover, crutches, durable medical equipment.