**EXETER HOSPITAL**
PATIENT ACCOUNTS
7 Holland Way Second Floor, Exeter, NH 03833 603.580.6627
Fax: 603.580.7946 Email: ehfinancialreps@ehr.org

NH Health Access NETWORK
*financial help – for your health*

## FINANCIAL ASSISTANCE APPLICATION



Date _____ Account #: _____

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 determine our ability to reduce those expenses for services provided at Exeter Hospital. 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. Exeter Hospital's Financial Assistance is not an insurance program and does not exempt you from the Accountable Care Act's requirement to have health insurance.

You may also be eligible for financial assistance with other participating providers of the NH Health Access Network. The NH Health Access Network is a network of hospitals and other health care providers that work to improve access to health care for uninsured and under-insured children and adult residents of the State of New Hampshire.

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. Please use the checklist below to be sure you have included all the information. The completed application and documentation must be returned to our office within 30 days. **We can not process your application without the required documentation.**

**If you have recently applied for financial assistance with Core Physicians, please contact our office at 603.580.6627 before completing this application**

1. Completed application with signatures.
2. A completed and **signed** copy of your **2023** Federal Income Tax Return, including **all schedules and W-2 forms.** If you are **not required** to file a tax return, please provide a copy of your **2023 SSA-1099 Social Security Benefit Statement.**
3. Copies of three (3) most recent paycheck stubs, unemployment, disability compensation, pension benefit statement and **2024 Social Security Benefit Statement** for each household member.
4. Copies of your last three (3) months of bank statements (e.g., savings, checking, money market, IRA, 401K, etc.), **all pages, for all accounts**.
5. Copies of government assistance notices (including Department of Health and Human Services).

Please use this checklist to ensure that all required information is submitted to correctly process your application. We reserve the right to request additional information regarding your credit evaluation, income tax return and verification of expenses versus your income, if necessary. All information provided is confidential.

You will continue to be financially responsible for any services you receive until eligibility is determined. If you are covered by any insurance and choose to receive services out of network, any denied balances or out of pocket expense will not be eligible for financial assistance. If you have not heard from us in 30 days after returning your application, or you need help in understanding it, please call our Patient Account office at 603.580.6627.

Sincerely,
Patient Accounts Department
Exeter Hospital, Inc.

#1639 (Eff. 01/2024 )
(Previously known as form 1084)
Rev. 09/2016, 1/17, 1/11/17, 5/17, 3/18, 1/19, 4/19,1/2020, 6/2020, 01/2021, 05/2021, 02/2022, 01/2023, 03/2023, 01/2024

**EXETER HOSPITAL**
PATIENT ACCOUNTS
7 Holland Way Second Floor, Exeter, NH 03833 603.580.6627
Fax: 603.580.7946 Email: ehfinancialreps@ehr.org

NH Health Access NETWORK
*financial help – for your health*

## FINANCIAL ASSISTANCE APPLICATION



### 1. Patient's Information

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

| Street Address | City | State | ZipCode | Length of time at address |
|---|---|---|---|---|
| | | | | |

| Mailing Address | City | State | ZipCode |
|---|---|---|---|
| | | | |

| Home/Cell Phone Number | Email Address | Check all that apply: | | | |
|---|---|---|---|---|---|
| | | ☐ Single | ☐ Married | ☐ Civil Union | |
| | | ☐ Divorced | ☐ Separated | ☐ Widowed | |
| | | ☐ US Citizen | ☐ NH Resident | | |

### 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:

| Name | Relationship to Patient | Date of Birth | Social Security Number | Primary Care Provider |
|---|---|---|---|---|
| 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.** Is anyone in your household pregnant? ☐ Yes ☐ No

**7.** Have you recently been approved for Financial Assistance through Core Physicians or any other facility?
☐ Yes ☐ No ☐ Pending If Yes, what is the effective date?_____

**8.** Has anyone in your household served in the military? ☐ Yes ☐ No Who:_____

**9.** Have you recently filed a workers' compensation, motor vehicle accident, or third party liability claim, or have you obtained an attorney in relation to the services received? ☐Yes ☐No Date:_____

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

**11.** Is anyone in your household covered by health insurance, Medicare or health savings account (HSA)?
☐ Yes ☐ No Name of Insurance Company:_____ Who:_____

**12.** Have you applied for coverage through the Healthcare Exchange? ☐ Yes ☐ No

**13.** Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who: _____

**EXETER HOSPITAL**
PATIENT ACCOUNTS
7 Holland Way Second Floor, Exeter, NH 03833 603.580.6627
Fax: 603.580.7946 Email: ehfinancialreps@ehr.org

NH Health Access NETWORK
*financial help – for your health*

## FINANCIAL ASSISTANCE APPLICATION



| 14. HOUSEHOLD INFORMATION | PERSON 1 | PERSON 2 | PERSON 3 |
|---|---|---|---|
| ***NAME of each household member:** | | | |
| **Name of employer** | | | |
| ***Gross Monthly income From:*** | | | |
| Employment | $ | $ | $ |
| Self-Employment | $ | $ | $ |
| Investment Accounts: | $ | $ | $ |
| Real Estate Rentals: | $ | $ | $ |
| Unemployment: (since ___/___/___) | $ | $ | $ |
| Retirement (Soc.Sec, 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:*** | | | |
| 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? | | | |

## 15. 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 Loan Balance $ _____

If other property is a business, list address: _____

Monthly Loan Payment: _____ Paid to: _____ For: _____

Monthly Loan Payment: _____ Paid to: _____ For: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Insurance: | | | Description: | | |
| Utilities: | $ | (Auto/Life/Property): | $ | Other: | | $ | |
| Alimony/Child Support: | $ | Health Insurance: | $ | | | $ | |
| Child Care | $ | Healthcare bills: | $ | | | $ | |
| Living (gas,food,clothes) | $ | Medications: | $ | | | $ | |

**OVER →**

**EXETER HOSPITAL**
PATIENT ACCOUNTS
7 Holland Way Second Floor, Exeter, NH 03833 603.580.6627
Fax: 603.580.7946 Email: ehfinancialreps@ehr.org

NH Health Access NETWORK
*financial help – for your health*

## FINANCIAL ASSISTANCE APPLICATION



**16. ASSIGNMENT OF RIGHTS** ***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.

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 will result in an automatic denial of 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 financial assistance.

I understand that any services that are the responsibility of a third party (i.e., automobile insurance, homeowners, lawsuit) are not eligible for the financial assistance program and 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.

I understand if I do not pay any balances due or copayments due, I will not be eligible to re-qualify for the program.

I understand that if I refuse to apply for coverage through the Healthcare Exchange or Medicaid Expansion, I will be ineligible to apply for financial assistance through this program. Also, if I have insurance, then voluntarily discontinue coverage, my Financial Assistance will be revoked.

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.

I understand that if I am approved for Financial Assistance, it will only cover active accounts with open balances and future services.

| Applicant Printed Name | Signature | Date |
|---|---|---|
| Co-Applicant Printed Name | Signature | Date |