UPPER CONNECTICUT VALLEY HOSPITAL
COMPASSIONATE HEALTHCARE...CLOSE TO HOME

Dear Applicant:

You may be able to get financial help from Upper Connecticut Valley Hospital (UCVH).

To get financial help through the UCVH Financial Assistance program you must have tried to get, and been refused, all other sources of payment including insurance, public assistance, or a lawsuit.

To find out if you or your household qualifies, you must give us proof of your income. Please fill out the attached application and sign it. Then, please send us that application and a COPY of each of the following for your household:

Documentation	**Attached**	**Not Required**
Complete copy of your most recent Federal Income Tax Return and all schedules		
Copies of the three (3) most recent, consecutive paycheck stubs or a statement from the employer.		
Copies of the three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, stocks, bonds, etc.)		
Copies of unemployment or disability compensation benefits statements		
Copies of pension benefits stubs		
Copies of social security income (yearly benefits statements, copy of check or direct deposit)		
Copy of Food Stamp allocation		
Copies of government assistance notices (including Department of Health & Human Services and Medicaid Spend Down Letter)		
Property Tax form if own property or Proof of Rent or Lease		

Please use this checklist to be sure we have all the information we need to quickly and correctly process your application. We may ask you for additional information about your credit evaluation and income tax return. The information you provide is confidential.

You will continue to be financially responsible for any services you receive until we have learned whether you qualify for help.

If you have not heard from us in 60 days after returning your application, or you need help in understanding it, please call Ginny at (603) 388-4234.

Sincerely,

Ginny

Return the application and requested documents to the hospital of your choice.

Revised 10/1/2016

UPPER CONNECTICUT VALLEY HOSPITAL
COMPASSIONATE HEALTHCARE...CLOSE TO HOME

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* | *Length of time at address*

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

Home Phone Number | *Work Phone Number*

☐ Single ☐ Married ☐ Civil Union
☐ Separated ☐ Divorced ☐ 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: Use additional sheet of paper if needed

	NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOC. SECURITY#	DOCTOR'S NAME
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 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:_____

UPPER CONNECTICUT VALLEY HOSPITAL
COMPASSIONATE HEALTHCARE...CLOSE TO HOME

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:$ _____

Medications $ _____ Other: $ _____ _____ _____

15. 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. 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* *C0-Applicant Signature* *Date*