The Elliot

A Member of SOLUTIONHEALTH

One Elliot Way
Manchester, NH 03103
603-663-7235

Financial Assistance Application Process

Please do not mail your application without the documentation requested below. Incomplete applications will delay the approval process and may be denied.

If you were a member of Manchester Community Health Center (MCHC) on the dates of service for which you seek assistance, please forward a copy of your MCHC card to our Patient Financial Services office (One Elliot Way, Manchester, NH 03103) to receive the appropriate discount. Financial Assistance is not an insurance program and does not exempt you from the Accountable Care Act's requirement to have health insurance.

If you are approved for financial assistance at any SolutioNHealth organization, please provide the approval notice in lieu of completing this application.

If an applicant was claimed as a dependent on the most recent year's tax return, we consider the financial situation of the guardian. All necessary documentation to support the guardian's financial situation must be provided.

The granting of Financial Assistance is based primarily on gross income and assets. Please send in all of the items below that apply to your situation:

- ☐ Employer Letter: If uninsured and employed, you must provide a letter from your employer indicating whether or not insurance is offered and if you are eligible for it.
- ☐ Proof of income: 3 most recent pay stubs from each income earner. If pay stubs are unavailable, written verification from the employer on company letterhead stating gross income earned and hire date is acceptable.
- ☐ Complete copy of most recent year's tax return, including all schedules — **Not W2s**. If you have not filed, send verification that you have not filed. Verification of non-filing can be obtained at a local IRS office or by calling 800-829-1040.
- ☐ If you receive Social Security or Pension Income: Please submit a copy of your check, or bank statement showing direct deposit.
- ☐ If you receive Unemployment or Worker's Compensation: Please send proof of any pay you may receive, along with the date such pay began.
- ☐ If no one on the application receives income: Please provide a **notarized** Letter of Support from the person supporting you, confirming it.
- ☐ If you receive assistance such as food stamps, fuel assistance, Medicaid, rent subsidy, etc.: Please send an approval letter or vouchers from any program for which you have been approved.
- ☐ If you receive child support: Please provide verification of payments along with frequency.
- ☐ Provide a copy of your property tax bill showing value of property, **and** a copy of mortgage statement showing balance of mortgage for all properties owned.
- ☐ 3 months of recent bank and investment statements (all checking and/or savings, money market accounts, 401K, IRA, etc. in your name) from the financial institution.

An applicant must apply for all available state and federal funding prior to requesting Financial Assistance.

Please return application and supporting documentation to:

Patient Financial Services Elliot Hospital One Elliot Way Manchester, NH 03103

Financial Assistance Programs*

<u>Financial Assistance:</u> Ensures that all individuals are able to receive medically necessary care at the Elliot Hospital regardless of their ability to pay. Patients must complete an application to be qualified for assistance. Charitable Care assistance can range from a patient having no financial obligation to some percentage of the outstanding balance. Elliot Hospital Financial Assistance Income Guidelines and policy can be found at: www.elliothospital.org/website/pay-my-bill-charitable-care-policy.php

<u>Catastrophic Relief Program:</u> Catastrophic Relief is available to provide substantial financial assistance to those patients who experience costly extended episodes of care at the Elliot Hospital due to serious sickness or injury. The program provides relief to uninsured patients whose financial responsibility to the Elliot Hospital exceeds $50,000 for any single episode of care.

If you are approved for financial assistance, you will receive an approval letter explaining your discount. If more information is needed to process your application, you will receive a letter explaining what is needed. Please do not consider the absence of correspondence as an approval, as incomplete applications may be denied after 30 days.

Patients denied Financial Assistance might appeal the decision in writing to the Charitable Care Appeal Committee. The Committee will review the appeal and render a written decision within 30 days of receipt. Appeals should be sent to the address below and addressed to the attention of: Charitable Care Appeal Committee.

Elliot Hospital
One Elliot Way
Manchester, NH 03103

If you feel you may qualify or have any questions about financial assistance, please contact an Elliot Financial Advocate at 663-7235 or visit our Patient Financial Services office in the main lobby of the Hospital.

*Elliot Hospital reserves the right to amend the policies and procedures set forth on this page in its sole and absolute discretion. The existence of these policies and procedures do not create any legal right for the benefit of any person. In short, while Elliot remains committed to helping those in need, it must preserve its right to adapt its policies and procedures as circumstances warrant. Elliot Hospital Patient Financial Services will make ultimate decisions regarding the application of these policies and procedures.

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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*

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 *Effective Date*

3. **Please indicate ALL people living in the household, including applicant: use additional sheet of paper if needed

	NAME	*RELATIONSHIP TO PATIENT*	*DOB*	*SOC. SECURITY #*	*PRIMARY CARE PROVIDER*
A		**SELF**			
B					
C					
D					
E					
F					

4. Has anyone in your household applied for public assistance such as Medicaid? ☐ Yes ☐ No Who: ____________

5. Has anyone in your household served in the military? ☐ Yes ☐ No Who: ____________

6. Have you recently filed a worker's compensation claim? ☐ Yes ☐ No Date: ____________

7. Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No Who: ____________

8. Is anyone in your household covered by health insurance? ☐ Yes ☐ No Who: ____________

Name of insurance company ____________

9. HOUSEHOLD INFORMATION

	PERSON 1	PERSON 2	PERSON 3
*NAME of each household member:	______	______	______
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:	$ ______	$ ______	$ ______
Other savings and investments:	$ ______	$ ______	$ ______
Specify: ______________	$ ______	$ ______	$ ______
Other:			
Value of Automobile:	$ ______	$ ______	$ ______
What is the Year, Make, Model?	______	______	______
Value of Recreation Vehicle?	$ ______	$ ______	$ ______
What is the Year, Make, Model?	______	______	______

10. 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, What is the Value? $__________

Monthly Loan Payment: $__________ Paid to: __________________ For: __________

Monthly Loan Payment: $__________ Paid to: __________________ For: __________

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

11. OTHER COMMENTS

☐ Check here if you have attached information you would like considered with your application.

12. 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.

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 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.

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 programs 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 change which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

____

Signature Date Co-applicant Signature Date