Wentworth-Douglass Hospital

FINANCIAL ASSISTANCE PROGRAM

Financial Assistance Application Cover Page
Wentworth Douglass Hospital & Wentworth Health Partners
Phone: 603-740-3234

Mail Application to:
789 Central Avenue Dover NH 03820
ATTN: Financial Assistance Office

In Person Assistance:
Wentworth-Douglass Business Systems
121 Broadway Avenue Dover NH 03820

Dear Applicant:

You may be able to get financial help from Wentworth Douglass Hospital & Wentworth Health Partners and possibly other healthcare organizations.

The NH Health Access Network is a group of hospitals, doctors and other health care providers in New Hampshire that work together to help children and adults when they cannot afford the health care they need.

The NH Health Access Network is for individuals who have insurance. To get financial help through the NH Health Access Network with out-of-pocket expenses your insurance must be active and accepted by and in-network with the provider. (Medicaid Spend Down Program is not insurance so those eligible for or enrolled in this program are not eligible for the NH Health Access Network.) If you have no insurance, financial assistance may be available from your provider; for more information, please contact a financial counselor at Wentworth-Douglass Hospital Business Office at 603-740-3234.

How to Apply

To find out if you or your household qualifies, you must complete the application and provide proof of income, and copies of the following documents:

Documentation that is required to be submitted with your application	Included
1. Complete copy of your most recent Federal Income Tax Return (1040 Form) and all supporting schedules, including last year's W-2 form(s) *OR If you do not file a tax return, you will be asked to sign a 4506T Form, which allows us to contact the IRS to verify a tax return was not filed* ❑ Check once 4506T Form is signed	
2. Copies of the three (3) most recent, consecutive paycheck regardless of pay cycle stubs or a statement from employer on company letterhead	
3. If Self Employed, 12 months (from current month) profit and loss statement required last years tax return will not be considered	
4. If you do not have an income, you will be asked to sign a No Income and Support Proclamation Form, which we require in order to process your application. Please request form	
5. Copies of three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) All accounts and ALL PAGES ARE REQUIRED (including blank pages) *a. If you do not have a bank account(s), you will be asked to sign a No Bank Account Proclamation Form, which we require in order to process. Please request form*	
6. Copies of unemployment or disability compensation benefits (include start date)	

Documentation that must be submitted with your application	Included
7. Copies of pension benefits	
8. Copy of Social Security income (yearly benefit statements, copy of check or direct deposit)	
9. Copies of Government Assistance Notices, including Department of Health and Human Services Spend Down & Copy of Food Stamp allocation, determination letter. a. *If no notice is available, you will be asked to sign an Authorization Form for the Department of Health and Human Services, which allows us to get the notice from the Department of Health and Human Services ALL PAGES ARE REQUIRED*	
10. Copy of Worker's Compensation (indicate date of injury)	
11. Copies of Child agreement, proof of payment with payment frequency, or a letter indicating proof of payment support paid and/or received	
12. If you are married but have separated from your spouse, a copy of your legal separation document is required from the court b. ***If you did not go through the court system for your separation, you will be asked to provide notarized statements of separation and/or lease agreements***	

****WE CAN MAKE COPIES FOR YOU OF ANY APPLICABLE DOCUMENTATION ****
Documents are NOT returned to applicants; they are scanned and securely destroyed.

Please note that elective procedures may not be considered for assistance
Please use this checklist to be sure we have all the information needed to quickly and correctly process your application. We may ask you for additional information, so please verify that the contact information you have listed is accurate.

- Cosmetic Surgery
- In-Vitro Fertilization (IVF)
- Advanced Reproductive Therapy (ART)
- Gastric Bypass Services absent of a payer's determination of medical necessity
- Accounts linked to a research study
- Patient Convenience items inclusive of premium accommodations and overnight accommodations that are based on a patient request and typically not covered by a health insurance plan
- Other non-medically necessary services that are billed according to a pre-determined self-pay fee schedule

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. To prevent anything from going to collections, a payment plan may be set up with billing 617-726-3884.

If you have not heard from us in 30 days after returning your application, or you need help in understanding it, please call our Financial Assistance Office at (603) 740-3234 and one of our representatives will assist you.

To view Wentworth-Douglass Hospital's Financial Assistance policy, go to www.wdhospital.org; Patient Services/

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In Person: 121 Broadway, Wentworth-Douglass Business Systems
Dover NH 03820
603-740-3234

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* *Zip Code* *Length of time at address*

Mailing Address *City* *State* *Zip Code*

Phone Number *Email Address*

Select applicable: ❑ 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 *Phone Number* *Email Address*

Name of Insurance Company (listed on year prior Tax Return) *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. Please fill out if anyone in your household has insurance:

Health insurance (Plan/Name)_____ , Health savings account (check) - ❑ Yes ❑ No Who: _____

Policy #/ID# _____ Deductible Amount: _____

Medicare Part A_____, Medicare Part B_____ Receives assistance to pay Medicare Part B _____Who: _____

6. Has anyone in your household applied for Medicaid? ❑ Yes ❑ No Who? _____

Who: _____ If Yes and denied please provide copy of the Medicaid denial notice.

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7. Have you applied for financial assistance at another facility? ❑ Yes ❑ No If yes, where: _____

8. Is anyone in your household pregnant? ❑ Yes ❑ No

9. Has anyone in your household served in the military? ❑ Yes ❑ No Who? _____

10. Have you recently filed a workers' compensation or motor vehicle accident claim? ❑ Yes ❑ No Date: _____

11. Is anyone in your household eligible for Social Security benefits? ❑ Yes ❑ No Who? _____

12. Does anyone else claim you on their income tax return? ❑ Yes ❑ No Who? _____

13. HOUSEHOLD INFORMATION	**PERSON 1 (Patient)**	**PERSON 2 (Spouse/Dependant)**	**PERSON 3 (Dependant)**
NAME of each household member:			
Name of employer:			
Monthly Income From:			
Employment:	$	$	$
Self-Employment:	$	$	$
Investment Accounts:	$	$	$
Real Estate Rentals:	$	$	$
Unemployment since _____ (Date)	$	$	$
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 - ***Read Carefully***

By signing below I authorize the request for my 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 may 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

Dependant Signature Date