Community Care Application

SPEARE Memorial Hospital
A Critical Access Hospital

1. Patient Information:

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

Street Address | City | State | Zip Code | Legth of Time at Address

Mailing Address | City | State | Zip Code

Phone Numbers: Home | Work | Cell

☐ Single ☐ Married ☐ Civil Union ☐ Separated ☐ Divorced ☐ Widowed ☐ US Citizen ☐ NH Resident

2. Person Responsible for Paying the Medical Bill:

Last Name | First Name | Middle Initial | Relationship to Patient | Social Security Number

Address if Different from Patient's | Phone Numbers: Home | Work | Cell

Name of Insurance Company | Effective Date | Patient ID Number | Subscriber Name & Date of Birth

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#*	*Applying Yes/No*
1.	**SELF**			
2.				
3.				
4.				
5.				
6.				

4. Please indicate for ALL people living in the household, including applicant:

a) Is this application for future or past services: ☐ Future ☐ Past Date(s) of Services: _____

b) Please fill out if anyone in your household has insurance: Plan Name _____

☐ Medicare Part A Policy #/ID# _____

☐ Medicare Part B Medicare #_____ Subscriber: _____ c)

Has anyone in your household applied for Medicaid? ☐ Yes ☐ No If yes, where:_____

Who: _____ If yes and denied, please provide a copy of the Medicaid denial notice. d) Have you applied for financial assistance at another facility? ☐ Yes ☐ No If yes, where:_____

e) Is anyone in your household pregnant? ☐ Yes ☐ No

f) Has anyone in your household served in the military? ☐ Yes ☐ No If yes, who: _____

g) Have you recently filed a worker compensation or motor vehicle accident claim? ☐ Yes ☐ No Date:_____

h) Is anyone in your household eligible for Social Security benefits? ☐ Yes Who:_____

i) Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who:_____

5. Please indicate for ALL people living in the household, including applicant:

	PERSON 1	PERSON 2	PERSON 3
NAME of each person:			
Name of employer:			
Gross Monthly Income from:			
Employment:			
Self Employment:			
Investment Accounts:			
Real Estate Rentals:			
Unemployment Since ____/____/____:			
Retirement (Soc.Security, Pension, Annuity):			
Savings & Investments			
Checking Account Balances:			
Savings & CD Account Balances:			
IRA(s), 403B, 401K:			
Other savings & investments:			
Specify_____:			

Other Automobile: Year_____ Make _____ Model _____

Recreational Vehicle(s): Year_____ Make _____ Model _____

Year_____ Make _____ Model _____

4. Household Expenses:

Monthly Rent $_____ 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: _____

Insurance (Auto/Life/Property): $_____ Utilities: $_____ Other: _____ $_____

Health Insurance Premium: $_____ Healthcare Bills: $_____ Other: _____ $_____ Living (gas, food, clothes): $_____ Medications: $_____ Other: _____ $_____ Alimony / Child Support: $_____ Child Care: $_____ Other: _____ $_____

5. 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 retroactively back to the date the bills owed. I may be liable for any and 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 healthcare or to their financial assistance eligibility. This information may be released to any healthcare providers from whom household members have south healthcare 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 Liability insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Community Care, 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