Dear Applicant:

As a New Hampshire resident, you may be able to get financial help from Speare Memorial Hospital and Speare Physician Practices.

To find out if you or your household qualifies for get financial help with your out-of-pocket expenses, you must give us proof of your income, savings, pension funds, etc. 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 Applicable**
Complete copy of your most recent Federal Income Tax Return and all schedules -**SELF EMPLOYED APPLICANTS ONLY**	☐	☐
Copies of three (3) most recent, consecutive paycheck stubs or a statement from the employer	☐	☐
Copies of three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) ALL PAGES	☐	☐
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)	☐	☐
Copies of government assistance notices (including Department of Health & Human Services and Medicaid Spend Down Letter)	☐	☐
Copies of Denial Notices from Medicaid	☐	☐
Copies of financial subsidies notices from Marketplace	☐	☐
Copies of Mortgage statement and property tax bill	☐	☐
Copies of Rental Agreement	☐	☐

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 income tax return. The information you provide is confidential.

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

If you have questions about completing the Community Care application, please contact Speare's Patient Financial Counselor, between the hours of 8:00 and 4:00 at (603) 238-6471 or email communitycare@spearehospital.com. If you would like to meet, please call to setup an appointment.

Community Care Application

SPEARE Memorial Hospital
A Critical Access Hospital

1. Patient Information:

Enter Text	Enter Text	Enter Text	Enter Text	Enter Text
Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Enter Text	Enter Text	Enter Text	Enter Text	Enter Text
Street Address	City	State	Zip Code	Length of Time at Address

Enter Text	Enter Text	Enter Text	Enter Text
Mailing Address	City	State	Zip Code

	Enter Text	Enter Text	Enter Text
Phone Numbers:	Home	Work	Cell

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

2. Person Responsible for Paying the Medical Bill:

Enter Text	Enter Text	Enter Text	Enter Text	Enter Text
Last Name	First Name	Middle Initial	Relationship to Patient	Social Security Number

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

Enter Text	Enter Text	Enter Text	Enter Text	Enter Text
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	Social Security #	Applying Yes/No
Enter Text	Enter Text	Enter Text	Enter Text	☐ Yes ☐ No
Enter Text	Enter Text	Enter Text	Enter Text	☐ Yes ☐ No
Enter Text	Enter Text	Enter Text	Enter Text	☐ Yes ☐ No
Enter Text	Enter Text	Enter Text	Enter Text	☐ Yes ☐ No
Enter Text	Enter Text	Enter Text	Enter Text	☐ Yes ☐ No
Enter Text	Enter Text	Enter Text	Enter Text	☐ Yes ☐ No

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: **Enter Text**

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

Policy #/ID#: **Enter Text** Subscriber: Enter Text

☐Medicare Part A: **Enter Text** Policy #/ID# **Enter Text**

☐Medicare Part B: **Enter Text** Subscriber: **Enter Text**

c) Has anyone in your household applied for Medicaid? ☐ Yes ☐ No If yes, where **Enter Text**

Who: **Enter Text** 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: **Enter Text**

e) Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No Who: **Enter Text**

f) Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who: **Enter Text**

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

	PERSON 1	PERSON 2	PERSON 3
Name of Each Person	**Enter Text**	**Enter Text**	**Enter Text**
Name of Employer	**Enter Text**	**Enter Text**	**Enter Text**
Gross Monthly Income from:			
Employer:	**Enter Text**	**Enter Text**	**Enter Text**
Self-Employment:	**Enter Text**	**Enter Text**	**Enter Text**
Real Estate Rentals:	**Enter Text**	**Enter Text**	**Enter Text**
Unemployed Since: (Date)	**Enter Text**	**Enter Text**	**Enter Text**
Retirement (Soc. Sec, Pension, Annuity):	**Enter Text**	**Enter Text**	**Enter Text**
Savings & Investments:			
Checking Account Balances:	**Enter Text**	**Enter Text**	**Enter Text**
Savings & CD Account Balances:	**Enter Text**	**Enter Text**	**Enter Text**
IRA(s), 403B, 401K:	**Enter Text**	**Enter Text**	**Enter Text**
Specify:	**Enter Text**	**Enter Text**	**Enter Text**
Other	***Year***	***Make***	***Model***
Automobile:	**Enter Text**	**Enter Text**	**Enter Text**
Recreational Vehicle(s):	**Enter Text**	**Enter Text**	**Enter Text**
	Enter Text	**Enter Text**	**Enter Text**

4. Household Expenses:

Monthly Rent $ **Enter Amount** or Mortgage Payment $ **Enter Amount** Mortgage Loan Balance $ **Enter Amount**

Property Tax Amount Not Included in Payment Amount Above: $ **Enter Amount**

Do You Own Property Other Than Primary Residence? ☐ Yes ☐ No

If yes, Mortgage Balance $ Enter Amount Property Tax Amount Not Included in Mortgage Payment: $ **Enter Amount**

If other property is a business, list address: **Enter Business Address**

Living (gas, food, clothes)	**$ Enter Amount**	Healthcare Bills:	**$ Enter Amount**	Auto Loans:	**$ Enter Amount**
Alimony/Child Support	**$ Enter Amount**	Student Loans:	**$ Enter Amount**	Personal Loans:	**$ Enter Amount**
Other: **Enter Text**	**$ Enter Amount**	Other: **Enter Text**	**$ Enter Amount**	Other **Enter Text:**	**$ Enter Amount**

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