

Community Care Application



1. Patient Information:

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Street Address at Address	City	State	Zip Code	Length of Time
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. <u>SELF</u>				
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