



# SeaCare

COORDINATING · COACHING · CONNECTING · CARING

11 Downing Court  
Exeter, NH 03833  
(603) 772- 8119

## 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

Mailing Address City State Zip code

Single  Married  Civil Union

Home Phone Number Work Phone Number  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 DATE OF BIRTH SOC. SECURITY# DOCTOR'S NAME

1 Self

2

3

4

5

4. Is this application for future or past services?  Future  Past Date(s) of Services: \_\_\_\_\_

5. Has anyone in your household applied for NH Healthy Kids or Medicaid?  Yes  No Who: \_\_\_\_\_

6. Have you applied for financial assistance at another facility?  Yes  No If yes, where: \_\_\_\_\_

7. Is anyone in your household pregnant?  Yes  No

8. Has anyone in your household served in the military?  Yes  No Who: \_\_\_\_\_

9. Have you recently filed a workers' compensation or motor vehicle accident claim?  Yes  No Date: \_\_\_\_\_

10. Is anyone in your household eligible for Social Security benefits?  Yes  No Who: \_\_\_\_\_

11. Please check if anyone in your household is covered by health insurance \_\_\_\_\_, health savings account \_\_\_\_\_, Medicare Part A \_\_\_\_\_, Medicare Part B \_\_\_\_\_ Receives assistance to pay Medicare part B \_\_\_\_\_ Who: \_\_\_\_\_

12. Does anyone else claim you on their income tax return?  Yes  No Who: \_\_\_\_\_

13. Are you a US Citizen?  Yes  No

NHHAN Revised 3/05, 9/05, 2/06, 9/06, 12/07, 8/09, 10/10

13. HOUSEHOLD INFORMATION	PERSON 1	PERSON 2	PERSON 3
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\*NAME of each household member: \_\_\_\_\_

Name of employer: \_\_\_\_\_

**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	\$ _____	\$ _____	\$ _____
IRAs, 403B, 401K:			
Specify: _____	\$ _____	\$ _____	\$ _____
Other savings and investments:			
Specify: _____	\$ _____	\$ _____	\$ _____

**Other:**

Automobile: Year, Make, Model? \_\_\_\_\_

Recreational Vehicle: Year, Make, Model? \_\_\_\_\_

14. HOUSEHOLD EXPENSES
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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 <i>Read Carefully</i>
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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 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