



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

Office use only

Recertification Request

Please complete the following questions and return with your proof of income in the enclosed envelope

Please make changes to name and address here:

Birth date: ___/___/___ Telephone: () _____ - _____

Email: _____

1. How many people are in your household: Adults _____ Children _____

2. List your total gross household income (*money earned by everyone in the house*)

We will need proof of income for each household member.*

(Please circle one for each)

Wages: _____	Weekly	Bi-weekly	Monthly	Yearly
Child Support/Alimony: _____	Weekly	Bi-weekly	Monthly	Yearly
Social Security: _____	Weekly	Bi-weekly	Monthly	Yearly
Unemployment: _____	Weekly	Bi-weekly	Monthly	Yearly
Other Income: _____	Weekly	Bi-weekly	Monthly	Yearly
Family Member Support: _____	Weekly	Bi-weekly	Monthly	Yearly

4. Do you have health insurance, Medicare/Medicaid (including Spend-Down): Yes/No
 (If yes, what do you have: _____ Deductible: \$ _____)

5. Is anyone in your household (adult or child) uninsured? Yes No
 If yes, how many: Adults _____ Children _____

***For proof of income, please enclose a copy of your most recent Income Tax Statement. If you do not file taxes, please enclose your last three pay stubs and your last three bank statements.**

Please complete the back of this form and sign your name.



6. Do you have a medical problem with which you need our help? Yes No .

If YES, please check below:

Prescription not filled	_____	X-ray not done	_____
Emergency Dental Care	_____	Eye Care	_____
Service not covered by SeaCare	_____	Other	_____

Explain: _____

7. Is there anything else you would like to tell us about SeaCare Health Services' physicians, therapists, staff, etc.?

* *SeaCare Health Services has information about the following services:*

<i>Asthma Management</i>	<i>ADD/ADHD</i>
<i>Parenting Support</i>	<i>Healthy Kid's Applications</i>
<i>Medication Bridge</i>	<i>Specialist Referrals</i>

Please check our website at www.seacarehealthservices.org, or call your Care Coordinator.

Please Sign below:

- **I agree to recertify for the SeaCare Health Services Program and follow their participant procedures and agreements given to me upon enrollment.**
- **All information provided on this form is correct to the best of my knowledge.**
- **We have provided you with an outline of our complete Privacy Practice Notice, "What is HIPAA and How Does It Affect Your Health Records?"**

Signature

Print Name

Date

Please remember to enclose proof of income with this form or we will not be able to process your new card.

www.seacarehealthservices.org