



Dear Applicant:

You may be able to get financial help from Monadnock Community Hospital and possibly other healthcare organizations. You will continue to be financially responsible for any services you receive until we know whether you qualify for help.

The NH Health Access Network is a group of hospitals, doctors and other health care providers in New Hampshire that work together to help children and adults when they cannot afford the health care they need.

The NH Health Access Network is for individuals who have insurance. To get financial help through the NH Health Access Network with out-of-pocket expenses your insurance must be active and accepted by and in-network with the provider. (Medicaid Spend Down Program is not insurance so those eligible for or enrolled in this program are not eligible for the NH Health Access Network.) If you have no insurance, financial assistance *may* be available from your provider; for more information, please contact a financial counselor at (603) 924-1717.

To find out if you or your household qualifies for the Health Access Network (for insured) or, otherwise, for financial assistance through your provider, you must give us proof of your income. 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:

- | Required                 | N/A                      |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. A complete copy of your most recent Federal Income Tax Return and all schedules*                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Copy of all most recent w-2 forms  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Copy of the three (3) most recent paycheck stubs or a statement from employer(s)*                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Copy of the three (3) most recent bank statements (e.g., savings, checking, money market, CD, etc.)* |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Copy of most recent retirement/investment (e.g., IRA, 401K, 403 B, stocks, bonds, annuity, etc.)     |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Copy of unemployment, disability compensation benefits statements                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Copy of social security and/or pension benefits  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Copy of dividend source, trust funds and property tax statement                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Copy of legal separation or domestic violence prevention paperwork                                   |
| <input type="checkbox"/> |                          | 10. Completed all pages of the application  |
| <input type="checkbox"/> |                          | 11. All adults have signed the application  |
| <input type="checkbox"/> |                          | 12. Copy of government assistance notices:  |
| <input type="checkbox"/> | <input type="checkbox"/> | Department of Health & Human Services notices (all pages)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Medicaid Spend Down Letters, Denial Notices from Medicaid   |
| <input type="checkbox"/> | <input type="checkbox"/> | Notices from Premium Assistance Plan(s) and Marketplace Insurance(s)                                    |

**\*If you are unable to supply proof of income, a tax return or bank statement, you may call (603)-924-1717 to request verification forms or visit us on the web at: [www.monadnockhospital.org](http://www.monadnockhospital.org) and print the forms out.**

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. 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 not heard from us in 60 days after returning your application, or you need help in understanding it, please call us at (603) 924-1717.

Sincerely,

The Financial Assistance Program  
Monadnock Community Hospital  
452 Old Street Rd  
Peterborough, NH 03458

**Return the application and requested documents to the hospital of your choice.**



## FINANCIAL ASSISTANCE ELIGIBILITY SUMMARY

### WHO CAN APPLY

- The Financial Assistance Program (FAP) policy provides free or discounted care for those who have tried all other payment options, and:
  - Have household income at or below 400% of the current year’s Federal Poverty Guidelines (see chart). Certain assets such as bank accounts or home equity may count toward this amount.
  - Have insurance or have visited our emergency department.
  - Have submitted a properly completed application within 8 months of the first post-discharge statement.

2021-2022 FEDERAL POVERTY LEVEL CHART	
Persons in Family/Household	400% of Poverty Guideline
1	\$51,520
2	\$69,680
3	\$87,840
4	\$106,000
5	\$124,160
6	\$142,320
7	\$160,480
8	\$178,640

### HOW TO APPLY

- In person at the MCH main campus, located at:  
452 Old Street Rd  
Peterborough, NH 03458
- By calling the FAP office:  
(603) 924-1717
- By visiting the MCH information desk or emergency department
- By going online to: [www.mchfinancialassist.org](http://www.mchfinancialassist.org)

### FOR FREE COPIES OF THE POLICY AND APPLICATION

- Use the contacts listed above.
- Interpreter services for other languages are available.

### ADDITIONAL INFORMATION

- Offices and physicians that accept the FAP are those which are MCH-owned.
- The FAP can only be applied toward medically necessary services.
- No patient with FAP will be charged more than other patients would normally be charged; Amount Generally Billed (AGB) for Fiscal Year 2021 is 47%.
- If you have any questions, contact the FAP office directly at (603) 924-1717

## 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	Length of time at address
Mailing Address	City	State	Zip code	
Home Phone Number	Work Phone Number	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> US Citizen <input type="checkbox"/> NH Resident		

### 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#	Applying Yes/No
1	Self			
2				
3				
4				
5				
6				

4. Is this application for future or past services?  Future  Past Date(s) of Services: \_\_\_\_\_
5. **Please fill out** if anyone in your household has insurance:  
 Health insurance (Plan/Name) \_\_\_\_\_ Health savings account?  Yes  No Who? \_\_\_\_\_  
 Policy #/ID# \_\_\_\_\_ Deductible Amount: \_\_\_\_\_  
 Medicare Part A \_\_\_ Medicare Part B \_\_\_ Receives assistance to pay Medicare Part B \_\_\_ Who? \_\_\_\_\_
6. Has anyone in your household applied for Medicaid?  Yes  No  
**If yes, who?:** \_\_\_\_\_ **If yes** and denied please provide copy of the Medicaid denial notice.
7. Have you applied for financial assistance at another facility?  Yes  No **If yes**, Where? \_\_\_\_\_
8. Is anyone in your household pregnant?  Yes  No
9. Has anyone in your household served in the military?  Yes  No **If yes**, who? \_\_\_\_\_
10. Have you recently filed a workers' compensation or motor vehicle accident claim?  Yes  No **If yes**, when? \_\_\_\_\_
11. Is anyone in your household eligible for Social Security benefits?  Yes  No **If yes**, who? \_\_\_\_\_
12. Does anyone else claim you on their income tax return?  Yes  No **If yes**, who? \_\_\_\_\_

**13. HOUSEHOLD INFORMATION****PERSON 1****PERSON 2****PERSON 3**

\*NAME of each household member:

Name of employer:

**Gross Monthly Income From:**

Employment: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Self-Employment: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Investment Accounts: (Dividends) \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

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 &amp; CD Account Balances \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

IRA, 401K, 403B \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Stocks, Bonds, Other \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Other**

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

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

**14. HOUSEHOLD EXPENSES**

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? **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 **If yes**, Amount \$ \_\_\_\_\_

Utilities \_\_\_\_\_ Insurance (Auto/Life/Property) \$ \_\_\_\_\_ Other: \_\_\_\_\_

Alimony/Child Support \_\_\_\_\_ Health Insurance Premium \$ \_\_\_\_\_ Other: \_\_\_\_\_

Child Care \_\_\_\_\_ Healthcare Bills \$ \_\_\_\_\_ Other: \_\_\_\_\_

Living (gas, food, clothes) \_\_\_\_\_ Medications \$ \_\_\_\_\_ Other: \_\_\_\_\_

**15. 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 retroactive back to the date the bills were owed. I may be liable for any/all 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 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 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 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