Monadnock COMMUNITY HOSPITAL

NH Health Access NETWORK
financial help – for your health

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; 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 complete the FAP application and return it with all needed documentation that applies to your household:

Required	N/A		
☐	☐	**1.**	A completed and signed application **(all adults have to sign the application)**
☐		**2.**	A complete copy of your most recent Federal Income Tax Return **including all schedules and attachments *or* for proof of non-filing status complete a 4506T***
☐	☐	3.	Copy of all most recent w-2 forms
☐	☐	4.	Copy of the 3 most recent paycheck stubs, unemployment stubs, or No Income/Support Verification form, Employer Verification form, Profit and Loss form, Self-Declaration Undocumented Deposits form *
☐	☐	5.	Copy of 3 most recent bank statement(s) from **all** accounts (e.g. savings, checking, money market, CD, Pay Pal, Venmo, etc.) * **Please do not print account histories; please provide full, actual statement including all pages**
☐	☐	6.	Copy of most recent statement(s) for retirement/investment accounts, dividend source, trust fund, property tax including asset value (**All that apply)** **Please do not print account histories; please provide full, actual statement including all pages**
☐	☐	7.	Copy of legal separation, divorce or domestic violence prevention paperwork
☐	☐	8.	Copy of Pension/Annuity benefit statement(s)
☐	☐	9.	Copy of Social Security income statement(s) showing your most recent monthly benefit amount
☐		10.	Copy of government assistance notices:
☐	☐		Department of Health & Human Services notices for Medicaid and SNAP (all pages for approvals and denials)
☐	☐		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 and print the forms out.**

Please use this checklist to be sure we have all the information we need to 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 service(s) you receive until we know whether or not you qualify for FAP. Please call (603) 924-4699, ext. 4281 to set up a payment plan. If you have not receive a decision 60 days after submitting a complete application (completed and signed application including all needed documents), or you need help in understanding it, please call us at (603) 924-1717.

Sincerely,

Monadnock Community Hospital
ATTN: FAP
452 Old Street Rd
Peterborough, NH 03458

02/2024

FINANCIAL ASSISTANCE ELIGIBILITY SUMMARY

WHO CAN APPLY

- The Financial Assistance Program (FAP) provides free or discounted care for those who have tried all other payment options, and:
    - Have gross household income including some assets at or below 400% of the current year's Federal Poverty Guidelines (see chart).
    - Have insurance or have visited our emergency department.
    - Have submitted a properly completed application within 8 months of the first post-discharge statement, that has not gone to bad debt.

2024-2025 FEDERAL POVERTY LEVEL CHART	
Persons in Family/Household	**400% of Poverty Guideline**
1	$60,240
2	$81,760
3	$103,280
4	$124,800
5	$146,320
6	$167,840
7	$189,360
8	$210,880

For families/households with more than 8 persons, add $5,380 for each additional person

FOR FREE COPIES OF THE POLICY AND/OR APPLICATION

- Refer to How to Receive an application/policy and/or apply
- Interpreter services for other languages are available

HOW TO RECEIVE AN APPLICATION/POLICY and/or APPLY

- By calling the FAP office for an application to be mailed: (603) 924-1717
- By visiting MCH and requesting an FAP application
- By going online to print the FAP application: https://monadnockcommunityhospital.com/financial-services/financial-assistance/
- Dropping application and documentation off at the Switchboard located at the Main Entrance
- Faxing an FAP application and documentation to: (603) 924-1709
- Mailing an FAP application and documentation to:

    Monadnock Community Hospital
    ATTN: FAP
    452 Old Street Rd.
    Peterborough, NH 03458

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 2024 is 51%.
- If you have any questions, contact the FAP office directly at (603) 924-1717

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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*

☐ Single ☐ Married ☐ Civil Union
☐ Separated ☐ Divorced ☐ Widowed
☐ US Citizen ☐ 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 a renewal _____, if no, is the application for ☐ Future or ☐ Past Date(s) of Services:_____

5. Please fill out if anyone in your household has insurance:

Health insurance _____ 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 & 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*