



Cottage Hospital

PO Box 2001

Woodsville NH 03785

Dear Applicant:

Hospitals in New Hampshire work hard to make quality health care available, affordable, and accessible to all, regardless of ability to pay. Cottage Hospital offers financial assistance and referral programs to ensure that cost will not be a barrier to anyone in our community getting the health care services they need. If payment of your health care expenses could create a financial hardship for you, our staff will work with you to apply for financial assistance for your medical needs. Information you provide is confidential and is only reviewed by staff processing your application.

Cottage Hospital has developed a charity care program based on the applicant's household income called Cottage Care to assist a patient with their need for healthcare services. Patients with limited financial resources may apply for 'Cottage Care'. The Cottage Care Program policy provides free or discounted care for those who have tried all other payment options, and have household income at or below 300% of the current year's Federal Poverty Guidelines.

As part of the financial counseling application process, the hospital will assess your potential eligibility for health insurance coverage through federal or state programs such as New Hampshire Medicaid. If it is determined that you may be eligible for one of these programs, the hospital will assist you in the application process. You will be required to supply the financial or medical documentation that is necessary to secure such insurance coverage.

To get financial help through the Cottage Care with out-of-pocket expenses your insurance must be active and accepted by and in-network with the provider. If you have no insurance, financial assistance *may* be available from your provider; for more information, please contact a financial counselor at (phone # and location).

To find out if you or your household qualifies for Cottage Care (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:

Documentation	Attached	Not Required
Complete copy of your most recent Federal Income Tax Return and all schedules		
Copies of most recent W-2 forms		
Copies of the three (3) most recent, consecutive paycheck stubs or a statement from the employer.		
Copies of the three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) ALL PAGES		
Copies of unemployment or disability compensation benefits statements		
Copies of pension benefits stubs		
Copies of social security income (yearly benefits statements, copy of check or direct deposit)		
Copy of Food Stamp allocation		
Copies of government assistance notices (including Department of Health & Human Services and Medicaid Spend Down Letter)		

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 about your credit evaluation and income tax return. 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 feel free to email us at customerservice@cottagehospital.org.

Sincerely,

Christina Burke

Patient Financial Counselor

customerservice@cottagehospital.org

603-747-9220

Revised 9/29/20

Cottage Hospital

Financial Assistance Application



1. Patient's Information:

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Social Security Number</i>	<i>Date of Birth</i>
<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip code</i>	<i>Length of time at address</i>
<i>Mailing Address</i>	<i>City</i>	<i>State</i>	<i>Zip code</i>	
<i>Home Phone Number</i>	<i>Work Phone Number</i>	<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

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Relationship to Patient</i>	<i>Social Security Number</i>
<i>Address if Different From Patient's</i>	<i>Home Phone Number</i>	<i>Work Phone Number</i>		
<i>Name of Insurance Company</i>	<i>Effective Date</i>			

3. ****Please indicate ALL people living in the household, including applicant:**

Use additional sheet of paper if needed

<i>NAME</i>	<i>RELATIONSHIP TO PATIENT</i>	<i>DATE OF BIRTH</i>	<i>SOC. SECURITY#</i>	<i>Applying Yes/No</i>
1	Self			
2				
3				
4				
5				

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 (circle) – Yes No **Who:** _____

Policy #/ID# _____ Deductible Amount: _____

Medicare Part A___, Medicare Part B___ Receives assistance to pay Medicare Part B _____ **Who:** _____

6. Has any household member applied for Medicaid? Yes No **Who:** _____ (provide copy of Medicaid denial)

7. Have you applied for financial assistance at another facility? Yes No If yes, where: _____

9. Has anyone in your household served in the military? Yes No **Who:** _____

10. Have you recently filed a workers' compensation or motor vehicle accident claim? Yes No **Date:** _____

11. Is anyone in your household eligible for Social Security benefits? Yes No **Who:** _____

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

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

Name of employer: _____

Gross 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:	\$ _____	\$ _____	\$ _____

14. HOUSEHOLD EXPENSES

Monthly Rent Payment: \$ _____ or Mortgage Payment: \$ _____ Mortgage Loan Balance \$ _____

Property Tax Amount Not Included in Payment Amount Above: \$ _____

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 Premium	\$	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.

In the event that I have not fully disclosed, or have inaccurately represented any income, 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