AMOSKEAG HEALTH

Dear Applicant:

You may be able to receive financial assistance from Amoskeag Health and posssibly other healthcare organizations. To find out if you or your household qualifies; you must provide us proof of your income. Please complete the attached application; if something does not apply to you pu n/a in that space, remember to sign and date the application. Please send us the completed application and a COPY of each of the following for your household:

Documentation Required for Processing	**Attached**	**Not Applicable**
Complete Copy of your most recent Federal Income Tax Return and all Schedules		
Copies of most recent W-2 forms		
Copies of last (4) most recent consecutive paycheck stubs or a statement from the employer. If paid bi-weekly, the last (2) most recent consecutive paycheck stubs.		
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)		
Other Miscellaneous sources of Income		
Copies of Denial notices from Medicaid, including Premium Assistance Plan		
Copies of financial Subisidies notices from Marketplace		

Attach all of the information on the check list that pertains to your situation

If you are not working and have no income, please include a written statement from the person who is providing support to you at this time. This statement in no way makes them responsible for your bill.

If you are not working and have no income and have no support from anyone, we will need a letter from you explaining your current situation before we can process the application.

AMOSKEAG HEALTH

Application for Financial Assistance/Amoskeag Health Medical Discount Card

Date of application: _____ Application is for: _____Indvidual _____ Family

Applicant First Name: _____ Last Name:_____

Date of Birth: _____/_____/_____ Check one: Single __ Married __ Separated __ Divorced __ Widowed __

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Please indicate ALL people living in the household, including applicant. Use additional sheet of paper if needed:

Name	Date of Birth	Relationship to Applicant	Gender (M/F)
Applicant		Yourself/Patient	

Does anyone else claim you on their income tax return? _____ Yes _____ No

Has anyone in your household applied for Medicaid? _____ Yes _____ No Status?: Pending____ Denied___

Is anyone in the household pregnant: _____Yes _____ No Due Date: _____

Is anyone in the household disabled: _____ Yes _____ No Name: _____

Does anyone in the household have medical insurance: _____ Yes _____ No If Yes, please provide a copy of the front and back of the insurance card(s).

Self attestation if unable to provide proof of income from an employer (paid in cash/off the books earnings):

I, _____, declare that I receive payment in cash for work performed.

How much do you get paid? $_____ How often do you get paid? _____

Type of work: _____

_____

Declaration of No Income (if you have no source of income please complete):

I, _____, declare that I have no source of income.
Please explain how you pay your current monthly living expenses such as rent, food, gas, clothing and medical care:

_____
_____
_____
_____

Please list all sources of income for the household. Income to be included, but not be limited to:

Employment wages	Self employment	Unemployment benefits	Social Security/SSI
Disability	Workers compensation	Rental income	Alimony/Child support
Veterans benefits	Investment income	Pension/Retirement distribution	
Income from estates/trusts	Public assistance (including TANF, food stamps, child care)		
Cash income and other income from outside the household		Other miscellaneous sources	

Household Income Information	**Person 1**	**Person 2**	**Person 3**
Name Each Member	_____	_____	_____
Gross Monthly Income From:			
Employment	_____	_____	_____
Self Employment	_____	_____	_____
Investment Accounts	_____	_____	_____
Real Estate Rentals	_____	_____	_____
Unemployment	_____	_____	_____
Retirement or Pension Documents	_____	_____	_____
Alimony/Child Support	_____	_____	_____
Public Assistance(TANF, SSI, Food Stamps,etc)	_____	_____	_____
Worker's Compensation	_____	_____	_____
Disability	_____	_____	_____
Income from Estates/Trusts	_____	_____	_____

You must answer every question. If something does not apply to you put N/A in that space. You must sign and date the application prior to submitting it. Missing information will result in your application being denied.

I certify that the information provided is true, and I am authorizing Amoskeag Health to verify that information, and release it to referring/mutual providers of care. I also agree to allow Amoskeag Health to share demographic and income data with City, State, Federal and Private grantors as necessary. I understand that I am financially responsible for all bills for services prior to completion and acceptance of this application and if my application is denied. I understand that Amoskeag Health is regulated by policies and regulations by the federal government and it is considered unlawful to misrepresent or falsely claim inaccurate information on this application.

_____ _____
Signature of Applicant **Date**

_____ _____
Signature of Spouse/Partner (if applicable) **Date**