CORE PHYSICIANS
an exeter health resource | The Art of Wellness

Date: _____ *Account No(s):_____*

Dear: _____:

If payment of your health care expenses could create a financial hardship for you, please fill out this application. This will help us to determine our ability to reduce those expenses for services provided by Core Physicians. Financial assistance will apply to services incurred starting six months prior to the date you are approved. Please answer **all questions** that apply to you or your household. Any information you provide is confidential and is reviewed only by the staff processing your application.

Before any financial assistance is granted, you must have already exhausted **all** other sources of payment including Insurance, Medicare, Medicaid Expansion, public assistance, litigation, and third-party liability. The completed application and documentation must be returned to our office as soon as possible to insure coverage of all dates of service. **We cannot process your application without the required supporting documentation. The required supporting documentation must be provided within 45 days of the application or the application will be considered closed.**

Please use this checklist to insure that all required information is submitted to quickly and correctly process your application. We reserve the right to request additional information, if necessary. All information provided is confidential.

1. Completed application (front & back) **dated and signed** by all adult applicants.
2. **A complete and signed copy** of your **2020** Federal Income Tax Return, **including all schedules and W-2 forms**. If you do not have a copy or did not file, please call the IRS at 1-800-829-3676 or go to www.irs.gov/transcript to request a copy of your return or a **non-filing verification** statement.
3. Copies of the **three (3) most recent consecutive paycheck stubs** or a statement from the employer, from each household member.
4. Copies of **three (3) most recent consecutive bank statements** (e.g., savings, checking, money market, IRA, 401K, etc.), **all pages,** for all accounts.
5. Copies of unemployment, disability compensation benefits statements, social security benefit statements and/or pension benefit income, government assistance (including Dept of Health & Human Services).
6. Copies of acceptance or denial from **Medicare, Medicaid Expansion and/or the Affordable Care Act.**
7. Copy of Food Stamp allocation.
8. Copy of Social Security Letter for 2021, stating how much you receive each month.

You will continue to be financially responsible for any services you receive until eligibility is determined. **Failure to pay responsibly on your account will affect your eligibility for Financial Assistance in the future**. If you have not heard from us in 30 days after returning your application, or you need help in understanding it, please call our Financial Assistance Office at (603)580-7232. Our office hours are Monday through Friday, 8:00AM til 4:30 PM.

Sincerely,

Financial Assistance Office
Core Physicians, LLC
7 Holland Way, 1st Floor
Exeter, NH 03833

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Financial Assistance Application

1. Patient Name Date of Birth SS#

Street Address

Mailing Address

Home Phone# Work Phone# Other#

Marital Status - Single __Married _Separated __Divorced _Widowed

2. Person Responsible for Paying the Bill

Name Date of Birth SS#

Address Phone#

Insurance information: HSA (Yes/No)

Have you applied for insurance through the Affordable Care Act?

If of age have you applied for Medicare Part B Part D

Have you applied for NH Medicaid through the Medicaid Expansion Act?

Do you wish to receive information about the Medication Bridge Program?

3. Please indicate ALL people living in the household (Name, Date of Birth, and Primary Care Dr.)

1)

2)

3)

4)

5)

(Please use additional sheet of paper if necessary)

4. Is this application for past dates of service? __Future Dates? Both?

5. Has anyone in your household applied for assistance recently with Exeter Hospital? __ Yes/No

7. Is anyone in your household eligible_for NH Healthy Kids or Medicaid? __Yes/No Who:

8. Are you a US Citizen? __Yes/No Greencard? Yes/No

9. Is anyone in your household Pregnant? Yes/No Who:

10. Has anyone in your household served in the military?___Yes/No Who:

11. Have you recently filed a claim for Worker's Comp? __Yes/No__Auto Accident? _Yes/No

12. Is anyone in your household eligible for Social Security Benefits? ___Yes/No___Who:

13 Does anyone else claim you as a dependent on their income tax return? _____Yes/No

14 Household Information

Name of adult household members 1. 2.

Name of Employer 1. 2.

Monthly Income from:

Employment/Self-Employment	$	$
Unemployment (since __/__/__)	$	$
Retirement (SS, Pension, Annuity…)	$	$
Alimony, Child Support,	$	$
Public Assistance, Food Stamps, SSI…	$	$

Savings & Investments:

Checking Account balances	$	$
Savings & CDs	$	$
IRAs, 403B, 401K, other…	$	$

Other Assets:

Automobile (year, make, model)	1.	2.
Recreational Vehicle (year, make, model)	1.	2.

15 Household Expenses - Monthly

Monthly Rent/Mortgage $ Mortg Balance $ Home Value $

Property Taxes not included above $ Value of 2nd Property $

Utilities $ Insurances $ Loans $ Child Care $ Other$

Alimony/Child Support $ Healthcare/Medications $ Living Exp(Food, Gas, etc)$

16 Assignment of Rights – Please 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 eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information I or someone else provides for me could cancel this application.

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 may 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 law suit 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.

Signature **Date** **Signature** **Date**