LITTLETON REGIONAL HEALTHCARE

Dear Applicant,

You may be able to get some help with your bill from Littleton Regional Healthcare (LRH). **We want to process your application quickly. Please wait to send us your application until you can check one or more of the statements in the box below.**

Before we begin you must show us that you've tried to get payment from one of the following.

- ☐ VT or NH residents must apply to Medicaid through the Department of Health and Human Services and turn in a notice of decision with the application.
- ☐ Lisbon NH residents must apply for the Lisbon's Buffington Fund at the Lisbon town office. You must turn in the determination letter of the decision with application.
- ☐ If applicable, all other applicants must show they have tried to get payment from Insurance, public assistance, and/or lawsuit.

We have a resource called **Littleton Care Program.** Its purpose is to help our patients who cannot afford health care. To get help with your bill, we need proof of your income. If you don't understand what we're asking for, please call us at 603-444-9560. We want to help you.

We process Littleton Care Program applications within 30 days of receipt. If you send us an application that's not complete, we will let you know. However, if, after 30 days it's still not complete, we will close and deny your application.

Please use the checklist on the back of this letter. Please send us all the information we need. Once you send us all of the paperwork, we will review your application. **The information you give us is strictly confidential.**

Please know that you need to pay for any services from LRH until we know if you meet the guidelines for help. If you have not heard from us **within 30 days** after sending us your application, please call us at 603-444-9560.

Sincerely,

Tara Ashey, ABA, CHAA, CAC
Financial Counselor

Ph.603-444-9560
Fax: 603-259-7561

Mail Completed application to: Financial Counselor, 600 St Johnsbury Rd. Littleton, N.H. 03561 or

Email to: tashey@lrhcares.org

Checklist

To review your application, we will need the following documents based on your household. Please wait to send us your application until you have all of these together.

We cannot review and approve your application if it's not complete. We process Littleton Care Program applications within 30 days of receipt. If you have not heard from us **within 30 days** after sending us your application, please call us at 603-444-9560.

Documentation	Attached
Before applying to LRH Charity Care you must obtain the following: Copy of government assistance notice from the Department of Health & Human Services (Medicaid/Expanded Medicaid).	
IF ANY OF THESE APPLY TO YOUR HOUSEHOLD, PLEASE PROVIDE A COPY	
Copies of the three (**3**) most recent paystubs if employed. If unemployed, please ask for a no income verification form.	
Complete copy of your most recent Tax Returns and **all pages/schedules.**	
Last Years W-2's	
Copies of the three (**3**) Most recent Banks statements **ALL PAGES** (Savings, Checking, Money Market, IRA, 401K, Prepaid card, ect.)	
Copies of unemployment or disability compensation benefit statements.	
Copies of Stocks Bonds, or CD's	
Copy of Child Support Order.	
Copy of Social Security income. (yearly benefit statement)	
Copy of pension benefits statement.	

Mail Completed application to: Financial Counselor, 600 St Johnsbury Road, Littleton N.H. 03561

NH DHHS Division of Family Assistance (DFA)
District Offices
How to Apply

1. You can apply in person at the NH DHHS office closest to you.
2. You can download the NH Medicaid or NH Health Protection Program application online at http://www.nheasy.nh.gov.
3. You can call Medicaid and they will mail the form to you (1-888-901-4999)

DFA Locations	Towns Served
Berlin 650 Main Street, Suite 200 Berlin; 03570-2431 Phone: 603-752-7800 or 1-800-972-6111	Berlin, Clarksville, Colebrook, Columbia, Dixville, Dummer, Errol, Gorham, Groveton, Milan, Millsfield, N. Stratford, Northumberland, Percy, Pittsburgh, Randolph, Shelburne, Stark, Stewartstown, Stratford, Wentworth's Location, W. Stewartstown
Conway 73 Hobbs Street Conway; 03818-6188 Phone: 603-447-3841 or 1-800-552-4628	Albany, Bartlett, Brookfield, Chatham, Chocorua, Conway, Eaton, Effingham, Freedom, Glen, Hale's Location, Hart's Location, Intervale, Jackson, Kearsarge, Madison, Melvin Village, Moultonborough, N. Conway, Ossipee, Sanbornville, Sandwich, Snowville, Tamworth, Tuftonboro, Wakefield, Wolfeboro
Littleton 80 North Littleton Road Littleton; 03561-3841 Phone: 603-444-6786 or 1-800-552-8959	Bath, Benton, Bethlehem, Carroll, Dalton, Easton, Franconia, Glencliff, Haverhill, Jefferson, Lancaster, Landaff, Lincoln, Lisbon, Littleton, Livermore, Lyman, Monroe, Piermont, Pike, Sugar Hill, Twin Mountain, Warren, Whitefield, Woodstock, Woodsville

Vermont Department of Health & Human Services
Saint Johnsbury District Office
How to Apply

1. You can apply in person at the VT DHHS in Saint Johnsbury.
2. You can apply online at www.greenmountaincare.org
3. You can call and they will mail you an application (1-800-250-8427)

Saint Johnsbury, VT
107 Eastern Ave., Suite 9
St. Johnsbury, VT 05819
1-802-748-5151

Financial Assistance Application

LITTLETON REGIONAL HEALTHCARE

1. Patient's Information

Last Name | First Name | Middle Initial | Social Security Number | Date of Birth

Street Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

Home Phone Number | Other Phone Number

Marital Status (circle one):

Single	Married	Civil Union	Separated	Divorced	Widowed

Citizenship Status (circle one):

U.S. Citizen	VT Resident	NH Resident

2. Person Responsible for Paying the Bill

Last Name | First Name | Middle Initial | Social Security Number | Date of Birth

Street Address | City | State | Zip Code

3. Household Information

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

Name	Relationship to Patient	Date of Birth	Social Security #	Applying for assistance?
1.				YES / NO
2.				YES / NO
3.				YES / NO

A. Is this application for future or past services? (circle) **FUTURE / PAST**

B. Does anyone in your household have insurance? (circle) **YES / NO**

Health Insurance Policy Name:

Policy / ID #:

Health Savings Account? (circle) **YES / NO**

C. Has anyone in your household applied for Medicaid? (circle) **YES / NO**

D. Have you applied for financial assistance at another facility? (circle) **YES / NO** If yes, where?

E. Is anyone in your household pregnant? (circle) **YES / NO**

F. Has anyone in your household served in the military? (circle) **YES / NO**

G. Have you recently filed a workers' compensation or motor vehicle accident claim? (circle) **YES / NO** If yes, when:

H. Is anyone in your household eligible for Social Security Benefits? (circle) **YES / NO**

I. Does anyone in the household pay child support? (circle) **YES / NO** If yes, monthly amount paid:

J. Does anyone else claim you on their income tax return? (circle) **YES / NO** If yes, who:

K. Are there any adults in the household who do not have any income? (circle) **YES / NO** If yes, who:

L. Are there any adults in the household who do not have any bank accounts? (circle) **YES / NO** If yes, who:

LITTLETON REGIONAL HEALTHCARE

Where good health begins.

4. Household Income Information

	Person 1	Person 2	Person 3
Name of each household member:			
Gross Monthly Income from:			
Employment:			
Self-Employment:			
Investment Accounts:			
Real-Estate rentals:			
Unemployment:			
Retirement:			
(Social Security, pension, annuities)			
Alimony / Child Support:			
Other income:			
Savings and Investments:			
Checking Account Balances:			
Savings & CD Account Balances:			
IRA, 401k, 403b Balances:			
Other savings & investments:			
Other:			
Automobile (Year, Make, Model)			
Recreational Vehicle (Year, Make Model)			

5. Household Expenses

Monthly Rent Payment:_____

Monthly Mortage Payment:_____

Medicare Part B, Part C, or Part D deducted from Social Security Check: _____

6. 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**