

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. When sending your application please go over the check list to make sure all documents necessary are enclosed.**

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 603-444-9000 and ask for the financial assistance department.

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.

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 603-444-9000.

Sincerely,  
Patient Advocate  
Littleton Regional Healthcare  
600 St. Johnsbury Road  
St. Johnsbury, VT 03561  
603-444-9560

# 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
<b>IF ANY OF THESE APPLY TO YOUR HOUSEHOLD, PLEASE PROVIDE A COPY</b>	
Copies of the three (3) most recent paystubs if employed. If unemployed, please ask for a no income verification form.	
<b>Complete copy</b> of your most recent Tax Returns and <b>all pages/schedules.</b>	
Last Year's W-2's	
Copies of the three (3) Most recent Banks statements <b>ALL PAGES</b> (Savings, Checking, Money Market, IRA, 401K, Prepaid card, etc.)	
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.	

**\*\*\*Please do not staple your documents\*\*\***

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

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

Financial Assistance Application



**1. Patient 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                      Other Phone

Marital Status (Circle One)

Citizenship Status (Circle if Applicable)

Single	Married	Civil Union	Separated	Divorced	Widowed
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U.S. Citizen	Vt. Resident	NH. Resident
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**2. Guarantor Information**

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

Street Address                      City                      State                      Zip Code

**3. Household Information**

A.) Please list all household members, including the applicant and all legally qualifying dependents. (Use additional sheet of paper if necessary.)

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

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

Health Insurance Provider:

Policy ID #:

Health Savings Account?

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

D.) Have you applied for Financial Assistance at another healthcare facility? (Circle) YES / NO

If YES, facility name?

E.) Is anyone in your household currently pregnant? (Circle) YES / NO

