Dear Applicant,

You may be able to get some help with your bill from Littleton Regional Healthcare (LRH). **When sending your application please go over the check list to make sure all documents necessary are enclosed.**

We have a resource called the **Financial Assistance 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.

2024 APPLICATION UPDATES: The applicant must apply for Medicaid, if deemed eligible by the LRH Patient Financial Advocate, who will utilize the NH Medicaid screening worksheet to determine eligibility to apply for such programs. The Medicaid application must be a cooperative one and any denial due to withdrawal of the application will be grounds for denial of the application for financial assistance. Individuals who have applied and have a pending application for a public assistance program are not eligible until an eligibility decision is reached. Individuals who chose not to enroll in Medicare Part B are not eligible for LRHs Financial Assistance.

Once you send us all of the paperwork, we will review your application. **The information you give us is strictly confidential.** We process 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 deny your application.

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,

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

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

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
Provide the following for all household members:	
PROOF OF INCOME	
ONE OF THE FOLLOWING: Copies of the four (4) most recent paystubs, last year's W-2s, or complete copy of your most recent Tax Return, with all pages/schedules.	
IF APPLICABLE: Copies of unemployment or disability compensation benefit statements; copy of child support order; Social Security statement (yearly benefit statement); pension benefit statements. Notice of Decision from a State or Federal Program that uses Federal Poverty Guidelines to determine eligibility (Medicaid, Food Stamps, WIC, etc.)	
If receiving no income, please request a no income form.	
AND	
PROOF OF RESOURCES/ASSETS	
Copies of three (3) Most recent Banks statements **ALL PAGES NEEDED** (Savings, Checking, Money Market, IRA, 401K, Prepaid card, etc.)	
If no bank account, please request a no bank account form.	
Copies of Stocks, Bonds, or CD's	

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

Mail completed application to: Patient Financial Advocate, 600 St Johnsbury Road, Littleton N.H. 03561

Financial Assistance Application

LITTLETON REGIONAL HEALTHCARE

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)

Single	Married	Civil Union	Separated	Divorced	Widowed

Citizenship Status (Circle if Applicable)

U.S. Citizen	Vt. Resident	NH. Resident

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 pap

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, faciity name?

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

F.) Have you recently filed a Worker's Compensation or Motor Vehicle Accid (Circle) YES / NO

If YES, Date of Accident?

G.) Is anyone in your household eligible for Social Security Benefits? (Circle) YES / NO

4. Household Information

Name of Household Member	1.)	2.)	3.)	4.)
Gross Monthly Income:				
Employment:				
Self Employment:				
Investment Income:				
Real Estate Rental Income:				
Unemployment:				
Retirement Income:				
Alimony / Child Support:				
Other Income:				
Assets:				
Checking Account Balances:				
Savings & CD Acct Balances:				
Retirement Acct Balances:				
Other Cash Assets:				

5. Assignment of Rights / Signatures *(Please Read Carefully)*

By signing below I acknowledge that I have read and understand the requirements to be considered for approved Financial Assistance. I agree to provide all necessary documents including bank statements, tax returns and all other information that is required in accordance with the Littleton Regional Healthcare Financial Assistance Policy, available via website or upon request.

I understand that in the event that I have not fully disclosed or have inaccurately represented any information required by this application, my approved status would be nullified, and I will be financially responsible for amounts that had previously been discounted. I further recognize that I may be responsible for any legal fees incurred in the collection process.

I and all household members who are represented in this application hereby authorize the release of any medical, financial, or employement information which is relevant to account balances for which this application is being submitted, and for the purpose of obtaining Financial Assistance. All information provided will remain confidential under the provisions of federal HIPAA regulations.

In the event that I may receive payment directly for healthcare services associated with this application, such as but not limited to insurance payments, government payments, awards from a lawsuit or other legal finding, etc., I hereby agree remit such funds up to but not greater than the amount of Financial that has been provided.

Signatures:

Household Member #1 **Date**

Household Member #2 **Date**

Household Member #3 **Date**

Household Member #4 **Date**