FINANCIAL INFORMATION

Name of Patient:_____Social Security #_____

Address_____Phone_____

City_____State_____Zip_____

HOUSEHOLD MEMBERS:

	Name	Age	Employer	Relationship to Patient
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

INCOME: List all Gross Income for Total Household Members for: Last Twelve Months

Wages……	_____
Farm/Self Employed…….	_____
Public Assistance……..	_____
Social Security/Disability Income…….	_____
Unemployment……..	_____
Workmen Compensation……...	_____
Strike Benefits……...	_____
Alimony…….	_____
Child Support……	_____
Military Family Allotments……..	_____
Pensions……	_____
Income From Dividends, Interest, Rent, Etc……	_____
Other…….	_____

EXPENSES: List All Expenses as Requested Below:	Average Cost	Monthly Payment
Medical and Dental(you may attach corresponding bills)….	_____	_____
Childcare…….	_____	_____
Rent or Mortgage……	_____	_____
Property Taxes (personal and real estate if not included in mortgage)……	_____	_____
Telephone……	_____	_____
Electricity……	_____	_____
Gas……..	_____	_____
Water……...	_____	_____
Food……	_____	_____

EXPENSES(Cont'd)

Other Expenses not listed on previous page:

_____

_____

_____

LIST ALL CARS, TRUCKS, BOATS, MOBILE HOMES, CAMPERS, MOTORCYCLES OR OTHER VEHICLES

	Make	Model	Year	Montly Payments	Amount Owed
1.					
2.					
3.					
4.					

List ALL Household Members Savings(including cash on hand, savings accounts, checking accounts, stocks, bonds, credit union, etc)

_____
_____
_____
_____

Does anyone in your household own any real estate, i.e. house, land, buildings(including the house you are living in) YES_____NO_____
If YES, you need to supply information about the value of the property, any amount owed, how the property is used:
VALUE:_____AMOUNT OWED:_____
HOW USED_____
WHAT STEPS ARE YOU TAKING IN ORDER TO IMPROVE YOUR CURRENT FINANCIAL SITUATION?
_____

Have you ever applied for Medicaid? YES_____NO_____
If <u>Yes</u> please attach denial, if <u>No</u> you must be denied before you can be considered for Charity.

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

_____ _____
Date Signature of Person Making Request

******FOR ADMISSIONS ONLY******

APPROVED_____DISAPPROVED_____

_____ _____
Signature Date

Note: This application must be filled out completely with supporting documentation attached to be considered

DHNH is under no legal obligation to provide this charity care. It does so in order to help members of the community who are actively trying to help themselves.

<u>Pre-Approval</u>

_____Completed, dated, and signed application

_____Estimated household income

<u>Completed Application</u>

_____Medicaid determination letter

_____Proof of household income