101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
603-536-4000
www.midstatehealth.org

Community Care Program (Sliding Scale) Application

If you are experiencing financial difficulty, we would encourage you to apply for our Community Care/Sliding Scale program. If you are eligible, it could greatly reduce your medical bills with Mid-State Health Center. The program is available to persons in a specific regional service area adjacent to Mid-State Health Center. Should you qualify, your fees for office visits will be reduced based on the sliding scale outlined on our Community Care Guidelines. Anyone who qualifies for our Community Care Program will be responsible for nominal fee based on their income level payable at the time of service. In some cases, we may be able to review accounts retroactively on a case-by-case basis (excluding any account balances already in collection).

Our Sliding Scale Program does NOT cover DOT physicals, "form" physicals, or any charges related to late cancellation or failure to keep a scheduled appointment.

We require that you complete the attached application form and return it to any Mid-State Health Center office within fourteen (14) days with the required supporting documentation listed below:

1. A copy of your most recent Income Tax Return filed with the IRS.
2. A copy of your last 4 pay stubs from your current employer. If you are not employed, you must send a notarized letter stating your last day worked, and by which means you are supporting yourself.
3. Copy of any State notifications regarding SSDI, SSI, Food Stamps and Medicaid.
4. A copy of your last 3 most recent bank statements of ***all accounts*** owned by you either individually or jointly. Please include ***all pages*** of each statement.
5. If you own a home we need a copy of your most recent mortgage statement showing your monthly payment amount and your loan balance and a copy of your most recent tax bill showing the assessed value of your home.
6. If you rent a home, a copy of your most recent rent receipt, cancelled check, or lease agreement.

Please note that your application cannot be processed without the required supporting documentation.

Failure to keep account balances current may result in denial of application renewal.

Should you have any questions regarding the Community Care/Sliding Scale program, please contact me directly at (603) 238-3586 for assistance.

Mid-State Patient Account Representative

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If you require larger print please ask.

Financial Assistance Application

1. Patient Information

Last Name *First Name* *M.I.* *SSN* *DOB*

Street Address *City* *State* *Zip Code*

Home Phone # *Work Phone #*

Check One: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

2. Person Responsible for Paying the Bill

Last Name *First Name* *M.I.* *Relationship to Patient* *SSN*

Address If Different from Patient's *Home Phone #* *Work Phone #*

Name of Insurance Company *Effective Date*

3. Please indicate ALL people living in the household, including applicant: use additional sheet of paper if needed

	NAME	RELATIONSHIP TO PATIENT	Date of Birth	Social Security Number	PCP
A		SELF			
B					
C					
D					
E					
F					

4. Have you applied for financial assistance at another facility? ☐ Yes ☐ No Facility:__________
5. Is this application for future or past services? ☐ Future ☐ Past Date(s) of Services:__________
6. Has anyone in your household applied for Medicaid? ☐ Yes ☐ No Who:__________
   When?________ What is the status? ☐ Pending ☐ Denied Reason:__________
7. Is anyone in your household pregnant ☐ Yes ☐ No
8. Has anyone in your household served in the military? ☐ Yes ☐ No Who:__________
9. Have you recently filed a workers' compensation claim? ☐ Yes ☐ No Date:__________
10. Is anyone in your household eligible for Social Security Benefits? ☐ Yes ☐ No Who:__________
11. Is anyone in your household covered by health insurance? ☐ Yes ☐ No Who:__________
    Name of Insurance: __________
12. Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who:__________

10. HOUSEHOLD INFORMATION

	PERSON 1	PERSON 2	PERSON 3
NAME of Each Household Member:	________	________	________
Name of Employer:	________	________	________
Monthly Income From:			
Employment:	$________	$________	$________
Self Employment:	$________	$________	$________
Investment Accounts:	$________	$________	$________
Real Estate Rentals:	$________	$________	$________
Unemployment: (since___/___/___)	$________	$________	$________
Retirement: (Soc. Security, Pension, Annuity)	$________	$________	$________
Alimony/Child Support:	$________	$________	$________
Public Assistance, Food Stamps:	$________	$________	$________
Other Income:	$________	$________	$________
Savings and Investments:			
Checking Account Balances:	$________	$________	$________
Savings & CD Account Balances:	$________	$________	$________
IRAs, 403B, 401K: Specify:________	$________	$________	$________
Other Savings and Investments: Specify:________	$________	$________	$________
Other:			
Value of Automobile:	$________	$________	$________
Year, Make, & Model:	________	________	________
Value of Recreation Vehicle:	$________	$________	$________
Year, Make, & Model:	________	________	________

11. HOUSEHOLD EXPENSES

Monthly Rent Payment: $__________ or Mortgage Payment: $__________ Mortgage Loan Balance: $__________
Property Tax Amt. Not Included in Payment Amt. Above: $__________ Value of Home: $__________
Do You Own Property Other Than Primary Residence? Yes No If Yes, What is the Value? $__________
Monthly Loan Payment: $__________ Paid to:__________ For:__________
Monthly Loan Payment: $__________ Paid to:__________ For:__________

Utilities:	$________	Insurance:	$________	Other:________	$________
Alimony/Child Support	$________	Health Ins:	$________	Other:________	$________
Child Care	$________	Healthcare Bills	$________	Other:________	$________
Living (gas, food, clothes)	$________	Medications	$________	Other:________	$________

12. Other Comments

___ Check here if you attached additional information you would like considered with your application.

13. 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.

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

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 of the medical services covered by this application, for example insurance payments, government program payments, away from a lawsuit or any other payment.

If I received 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