

Financial Assistance Policy – Plain Language Summary

Concord Hospital is committed to improving the health of the community by ensuring everyone has access to medical care regardless of ability to pay. Concord Hospital's Financial Assistance Program is designed to provide eligible patients full or partial discounts on their bills for emergency or medically necessary healthcare. This is a summary of Concord Hospital's Financial Assistance Policy and the financial assistance application process.

Program Eligibility

- ❖ Our Financial Assistance Policy provides free care for those who have tried all other payment options (such as Medicare, Medicaid and the health insurance marketplace), and have household income at or below 225% of the Federal Poverty Guidelines.
- ❖ Have submitted a properly completed financial assistance application along with required documentation.
- ❖ This reduction applies to uninsured and insured patients who owe balances after insurance payments have been made.
- ❖ Our policy also includes catastrophic assistance for uninsured patients with household income between 225% and 500% of the Federal Poverty Guidelines who have experienced a medical hardship and owe large medical bills.
- ❖ There are certain services not eligible for financial assistance, such as cosmetic services, reproductive medicine or elective non-covered services as specified by Medicare and other third party coverage guidelines.
- ❖ No person eligible for financial assistance will be charged more for care than amounts generally billed to individuals who have insurance covering emergency or other medically necessary care.

Where to Find Information

There are many ways to find information about our Financial Assistance application process, or get copies of our Financial Assistance Policy or application form. To apply for financial assistance you may:

- Download the information online at www.concordhospital.org
- Request the information in writing by mail or by visiting a Financial Counselor at Concord Hospital, 250 Pleasant Street, Concord NH 03301.
- Request the information directly by calling 603-227-7101 or email financialcounseling@crhc.org
- Request a Financial Assistance Application at any check-in or registration area

How to Apply

- [Complete a financial assistance application](#) and submit it along with the following:
 - Complete a copy of your most recent Federal Income Tax Return and all schedules. Include copies of last year's W-2 forms
 - Copies of the three most recent, paycheck stubs or a statement from the employer
 - Copy of your most recent bank statement (e.g., savings, checking, money market, IRA, 401K, etc.)
 - Copies of unemployment, disability compensation benefits statements
 - Copies of social security or pension benefit income
 - Copy of food stamp allocation
 - Copies of government assistance notices (including the Department of Health & Human Services)
 - If you do not have all of these documents contact one of our financial counselors.

Decision & Notification

Every effort is made to finalize the decision after receipt of a complete application. Decisions are reviewed and approved by either a supervisor or a director. Notification of a decision is sent in writing.

Concord Hospital will not discriminate in the determination of financial assistance eligibility on the basis of race, color, ethnic origin, sexual orientation, marital status, creed, age, sex or disability.

Availability of Translations

The Financial Assistance Policy, application form and the plain language summary can be offered in English and Spanish or any other language upon request. For more information, please call 603-227-7101.



Financial Assistance

250 Pleasant Street Concord, NH 03301
(603)227-7101 or toll-free: 1(800)562-1542
TTY/TTD: (603)230-7455 or TTY/TTD toll-free: 1(888)833-4408
concordhospital.org

Email: financialcounseling@crhc.org
Fax: 603-227-7545

Financial Assistance applies to all Concord Hospital locations, including Concord Hospital-Laconia and Concord Hospital-Franklin

To complete your application for financial assistance through Concord Hospital, you must provide the following documents that apply:

Required N/A

- Complete both sides of the application and sign the bottom
- A copy of your complete, current Federal Income Tax Return with all schedules. If you do not file taxes, there is a box to check on the back of the application.
- Copies of your 3 most recent, consecutive paycheck stubs or a statement from the employer
- Complete copy of your most recent bank statements (savings, checking, IRA, 401K, etc.) All pages, showing all Transactions. (Savings, Checking, IRA, 401K, Retirement, Investment, Electronic Transactions, etc..)
- Copy of unemployment or disability compensation benefits statements
- Copy of pension benefits stubs
- Copy of social security income (yearly benefits statements, copy of check or direct deposit)
- Copy of Department of Health & Human Services decision letters (Medicaid, Food Stamps, etc.)

The information you provide is confidential. If you would like your documents returned to you, please provide a self-addressed envelope.

You will continue to be financially responsible for any services you receive until we have determined whether you qualify for assistance. We encourage you not to discontinue care while your application is being processed. If you need assistance with your prescriptions, please call the Prescription Assistance department for an application at 603-227-7009.

Financial Assistance may not apply to any account(s) that have been sent to a collection agency. It also does not cover services rendered by outside entities. Financial Assistance is not available for prescription drugs, cosmetic procedures, complementary medical services, outpatient preventive dental services unless provided at Concord Hospital Family Health Center and Laconia Dental Clinics, investigational services, or elective non-covered services as specified by Medicare and other third party coverage guidelines. Concord Hospital reserves the right to determine if a service will be considered under Financial Assistance.

Sincerely,
Concord Hospital

Financial Assistance Application

*If you would like your supporting documents returned to you, please provide a self-addressed envelope.

1. Patient's Information:				
Last Name	First Name	MI	Social Security Number	Date of Birth
Street Address		City	State	Zip Code
Mailing Address <input type="checkbox"/> same as above		City	State	Zip Code
Phone Number	Alternate Phone	Primary Care Physician		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
2. Person responsible for paying the bill:		<input type="checkbox"/> Same as the Patient		
Last Name	First Name	MI	Social Security Number	Date of Birth
Address (if different from patient's)		City	State	Zip Code
Phone Number	Alternate Phone	Relationship to Patient		
3. Indicate all people living in the household:		*Use additional sheet of paper if needed.		
Name	Relationship	Social Security No	Date of Birth	Insurance Plan
Same as the Patient	Self	See Above	See Above	
4. Are you applying for past or future services?		<input type="checkbox"/> Past <input type="checkbox"/> *Future		
*Please describe future services needed:				
5. Name anyone in your household that is pregnant:				
6. Name anyone in your household that recently applied for Medicaid:				
7. Does anyone else claim you on their income tax return?		<input type="checkbox"/> No	<input type="checkbox"/> *Yes	Who?

8. Gross Monthly Income Information (before taxes) for each member of the household			
	Person 1	Person 2	Person 3
Name of Household Member:			
Name of Employer:			
Employment:	\$	\$	\$
Self-Employment:	\$	\$	\$
Unemployment:	\$ Date	\$ Date	\$ Date
Social Security:	\$	\$	\$
Pension:	\$	\$	\$
Annuities:	\$	\$	\$
Alimony/Child Support:	\$	\$	\$
Public Assistance:	\$	\$	\$
Real Estate Rental Income:	\$	\$	\$
No Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Financial Account Balances (most recent) *Please list all accounts for each member of household.			
	Person 1	Person 2	Person 3
Checking Account:	\$	\$	\$
Savings Account:	\$	\$	\$
Retirement Account: (IRA, 403b, 401K or CDs)	\$	\$	\$
No Bank Accounts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



By checking this box, I attest that I/we did not file taxes last year.

10. Recent changes to your finances (ex: out of work, unexpected injury)

Financial Assistance is available for medically necessary services only. Financial Assistance will not apply to any account(s) that have been assigned to a collection agency.

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