Weeks Medical Center

NH Health Access NETWORK
financial help – for your health

Financial Assistance Application

1. Patient's Information:

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

Street Address | *City* | *State* | *Zip code* | ***Length of time at address***

Mailing Address | *City* | *State* | *Zip code*

Home Phone Number | *Work Phone Number*

☐ Single ☐ Married ☐ Civil Union
☐ Separated ☐ Divorced ☐ Widowed
☐ US Citizen ☐ NH Resident

2. Person Responsible for Paying the Bill

Last Name | *First Name* | *Middle Initial* | *Relationship to Patient* | *Social Security Number*

Address if Different From Patient's | *Home Phone Number* | *Work Phone Number*

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*	*SOC. SECURITY#*	*DOCTOR'S NAME*
1		**Self**			
2					
3					
4					
5					
6					

4. Is this application for future or past services? ☐ Future ☐ Past Date(s) of Services:_____

5. Has anyone in your household applied for Medicaid? ☐ Yes ☐ No Who:_____

6. Have you applied for financial assistance at another facility? ☐ Yes ☐ No If yes, where:_____

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 or motor vehicle accident claim? ☐ Yes ☐ No Date: _____

10. Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No Who:_____

11. Please check if anyone in your household is covered by health insurance_____ , health savings account_____,

Medicare Part A_____, Medicare Part B_____ Receives assistance to pay Medicare Part B_____ Who:_____

12. Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who:_____