

**END STAGE RENAL DISEASE
FIRST APPLICATION**

Please return Application to:

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF ELDERLY & ADULT SERVICES
CATASTROPHIC ILLNESS PROGRAM
129 PLEASANT STREET
CONCORD NH 03301-3857
TOLL FREE NUMBER: 1-800-852-3345 EXT. 4495
OR DIRECTLY AT (603) 271-4495
FAX#: (603) 271-7985

DATE: _____

NAME: _____ DATE OF BIRTH: _____
Last First MI

ADDRESS: _____ TELEPHONE: _____

_____ COUNTY: _____
City State Zip

SOCIAL SECURITY NUMBER: _____ MALE: _____ FEMALE: _____

MARITAL STATUS: YES NO U.S. CITIZEN: YES NO VETERAN: YES NO

NUMBER OF CHILDREN LIVING WITH YOU: _____ AGES: _____

HEALTH INSURANCE

A. MEDICARE (PLEASE COPY FROM YOUR CARD)

CLAIM NUMBER: _____ SEX: _____

IS ENTITLED TO: HOSPITAL: YES NO EFFECTIVE DATE: _____

MEDICAL: YES NO EFFECTIVE DATE: _____

B. MEDICAID (WELFARE)

HAVE YOU APPLIED FOR MEDICAID? YES NO IF YES, DATE: _____

MEDICAID IDENTIFICATION NUMBER: _____

DISTRICT OFFICE: _____

GROSS INCOME: _____ / PER YEAR

THIS SECTION FOR OFFICE USE ONLY:

CASE #: _____ REF. CODE: _____

PROG. CODE: _____ / _____ / _____ / _____ / _____

CONTACT PERSON: _____

ICDA CODE: _____

INS: _____

M: _____

A: _____ B _____ C _____

D: _____ E _____ F _____

ELIG: YES NO AUTH: YES NO

We support Title VI of the National Civil Rights Act of 1964. NH Dept. of Health & Human Services staff and programs do not discriminate because of race, color, national origin, age, sex, religion, political affiliation or handicap. If you have a concern, please call (603) 271-2767 or 225-4033 for TDD. The in-state toll free number is 1-800-852-3345.

MONEY COMES FROM:

_____ SOCIAL SECURITY: _____ / MONTHLY

_____ PAYCHECK FROM JOB: _____ / MONTHLY

_____ COPY OF W-2 FORM OR COPY OF FEDERAL 1040 INCOME TAX STATEMENT

_____ OTHER (PENSION, VA, CHILD SUPPORT, ETC.) _____

SPOUSE'S GROSS INCOME: _____ / YEARLY

MONEY COMES FROM: _____

OTHER INCOME: _____ SAVINGS: _____

INVESTMENTS: _____ IRA: _____

MEDICAL HISTORY

DIAGNOSIS: _____

DATE OF ONSET: _____

NAMES OF SPECIALISTS WHO ARE TREATING YOUR ILLNESS. PLEASE INCLUDE THEIR FULL NAME AND TITLE:

NAME OF FAMILY PHYSICIAN: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____

I HEREBY DECLARE That these financial statements are correct and true to the best of my knowledge. I realize that the Catastrophic Illness Program receives its funds from the State Legislature, and that any intentional misrepresentation may result in legal action against me on the basis of State laws. I also understand that I may be asked to provide evidence of income, medical expenses, medical diagnosis verification and treatment status as well as health insurance and Medicaid status to the Catastrophic Illness Program.