



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
Tuberculosis Financial Assistance Program
(603) 271-4502 (800) 852-3345 x4502
(603) 271-0545 fax

<u>Presumptive eligibility</u>
<input type="checkbox"/> Yes <input type="checkbox"/> No
Office Use Only

NH TB FINANCIAL ASSISTANCE APPLICATION

Date of application: _____

Last Name	First	M.I.
Street Address	City/Town	State Zip
Mailing Address (if different than above)		
Home phone ()	Work phone ()	Cell phone () Other phone ()
E-mail address		
Date of Birth:		
NH Resident: Yes No	Birth Country:	Male Female Transgender
Can we leave a detailed message on your answering machine? Yes No No machine		
If no, who can we contact? Name: Phone: () Relationship:		
Can we mail information to the above address? Yes No		
If no, what address can we mail to?		
PH Nurse Case manager:		Office Location:
Primary physician: Phone: ()		City/Town:
Specialty care physician: Phone: ()		City/Town:
Pharmacy: Phone: ()	Street: City/Town:	
Housing status: permanent temporary homeless institution		

DEMOGRAPHIC INFORMATION

1. What language do you speak most often? English Spanish French Other (explain): _____
2. Which of the following best describes your race? White Black or African American Asian
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native More than one race
3. Which of the following best describes your ethnicity? Hispanic/Latino Non-Hispanic/Latino

INCOME INFORMATION

Number of persons in your household?

Source(s) of income:	Weekly	Monthly	Yearly
Wages	\$	\$	\$
Other (explain):	\$	\$	\$
Other (explain):	\$	\$	\$
Other (explain):	\$	\$	\$
Totals:	\$	\$	\$

Proof of income, most recent: (submit one of the following)

Pay Stubs	Social security or unemployment check
Federal Income Tax	Bank Statement
Employer letter stating wages	Other (explain):

Note: If your income exceeds 200% of the federal poverty level, proof of medical expenses may be submitted to "spend down" and qualify you for the program, see below.

MEDICAL EXPENSES

In the last 12 months, what were your total out-of-pocket household medical expenses (i.e., those not covered by Medicaid, medical insurance to any other third-party payer)? Include those expenses that you have already paid and those you have not yet paid:

\$ _____

MEDICAID INFORMATION

Do you have Medicaid coverage? Yes No	Date applied:
Approved: Yes No Pending	ID #

MEDICARE INFORMATION

Part A: Yes No Unknown	Start Date:
Part B: Yes No Unknown	Start Date:

MEDICARE PART D INFORMATION

Part D: Yes No Unknown	Start Date:
Plan name:	
ID #	

INSURANCE

Are you covered by a medical health plan (including private insurance)? Yes No	
Medical plan name:	ID#
Medical plan name:	ID#

By signing below, I certify that I have read, understand, and comply with the Non-Discrimination Notice, Client Certification, and Grievance Procedure

Non-Discrimination Notice

The State of New Hampshire, Department of Health and Human Services, does not discriminate against people because of their age, sex, race, creed, color, marital status, familial status, physical or mental disability, national origin, sexual orientation or political affiliation or belief. There will be no discrimination in accepting or providing services, or the admission or access to, or treatment or employment in, any of the Department's programs or activities. The Controller is responsible for coordinating the civil rights compliance efforts of the Department, component offices and divisions to follow state and federal rules against discrimination. For more information, or to learn how to make a discrimination complaint, contact the Controller at 129 Pleasant Street, Concord, New Hampshire 03301; or you may telephone (603) 271-4963 (voice) or the TDD Access number: 1-800-735-2964. The New Hampshire Department of Health and Human Services is subject to Title VI of the Civil Rights Act of 1964 (42 U.S.C., Section 2000d et. seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C., Section 794); Title IX of the Education Amendments of 1972 (20 U.S.C., Section 1681); the Age Discrimination Act of 1975 (42 U.S.C., Section 6101 et. seq.); NH RSA 354-A; and certain federal block grant statutes, including, but not limited to 42 U.S.C., Sections 300x-7, and 708, or any other provision through which the Department receives federal financial participation in its programs. These laws prohibit discrimination on the basis of age, sex, race, creed, color, marital status, familial status, physical or mental disability, national origin, sexual orientation or political affiliation or belief in federally-assisted and state funded activities. The U.S. Department of Health and Human Services' regulations under Title VI, Section 504, Title IX and the Age Discrimination Act are found at 45 C.F.R., Parts 80, 84, 86 and 91, respectively. The New Hampshire Department of Health and Human Services is further subject to the Americans with Disabilities Act of 1990 (42 U.S.C., Section 12101, et. seq.) and its implementing regulations at 28 C.F.R., Part 35.

Client Certification

1. I hereby declare that my financial statements are correct and true to the best of my knowledge. I realize that the NH TB Financial Assistance Program receives its funds from the State of New Hampshire and that any intentional misrepresentation may result in legal action against me on the basis of state or federal laws. Furthermore, I understand that I will be denied participation if I withhold information, provide inaccurate information, or refuse to provide all of the necessary information. I agree to notify the NH TB Financial Assistance Program within 30-days of any change in my name, address, eligibility, financial, insurance status or household size, and to provide evidence of income and medical expenses, Medicaid or Medicare status, health insurance policy. I fully agree to comply with the conditions stated above.
2. In order to be considered for participation in the NH TB Financial Assistance Program, I hereby authorize my physician or his/her representative to release information requested by the NH TB Financial Assistance Program relative to the content of my medical record. I understand that this information will be maintained under strict conditions of confidentiality and that my identity will not be revealed to any persons outside of the Dept. of Health and Human Services. All information given to the NH TB Financial Assistance Program is strictly confidential and will not be released to any other parties unless allowed under the law.
3. I hereby authorize the staff of the NH TB Financial Assistance Program to communicate with and release information, including my diagnosis, to appropriate physicians and other health care professionals including my pharmacist, case manager and other treatment providers, to ensure the best possible planning and delivery of services on my behalf. This release is valid for one (1) year from signature unless revoked by me in writing.

Grievance Procedure

1. If you are dissatisfied with eligibility determination, you may request, within 30 days of the date of the NH TB Financial Assistance Program's notification letter, an informal case review conference.
2. The NH TB Financial Assistance Program shall notify you within 14 days after the case review conference whether the NH TB Financial Assistance Program concurs, modifies, or revokes the determination.
3. If you or your guardian is dissatisfied with the result of the case review, a request may be made within 30 days of notification of said result, an adjudicative proceeding which shall be held in accordance with RSA 541-A.
4. You must contact the NH TB Program Manager if you're denied eligibility. If then, you are still dissatisfied with the response, contact the Section Chief at 800-852-3345 x4481
5. You may contact the Office of Ombudsman at any point in the process for neutral resolution of your complaint at 800-852-3345 ext. 6941.

Applicant/Guardian Signature

Date

Witness Signature

Date

Physician's Release of Information

I hereby authorize my physician or physician's representative, to release information requested by the NH Division of Public Health Services, relative to the content of my medical record. I understand that the NH Division of Public Health Services may release such information when necessary for the proper provision of medical care. I understand that this information will be maintained under strict confidentiality, and is to be used for my ultimate benefit. This release is valid for one (1) year from date of signature unless revoked by me in writing.

Applicant/Guardian Signature _____ Date _____

Printed Name _____

Witness Signature _____ Date _____

Physician's Information

Physician Name _____

Hospital/Clinic Name _____ City/Town _____

Phone # _____ Fax # (optional) _____

APPLICANT CHECKLIST

- Complete my personal information on this application and include a phone number where I can be reached.
- Attach a copy (if available) of my medical health insurance card and write in the information on page 2.
- Attach a copy (if available) of my prescription or part D card and write in the information on page 2.
- Attach a copy of my pay stub OR social security check OR unemployment check OR federal income tax return. If I don't send proof of income I could be denied enrollment.
- No Income: attach a letter from my Public Health Nurse Case Manager, which states this and explains how I get food and shelter.
- Mail my application to:

**DHHS-DPHS
TB Financial Assistance Program
29 Hazen Drive
Concord NH 03301**

Call the NH TB Financial Assistance Program if you have ANY questions about completing this application.

NH TB Financial Assistance Program Hours
8:00 – 4:30
Monday thru Friday

Main Office: (603) 271-4502 (800) 852-3345 x4502

He-P 301.17 Tuberculosis Patient Care Financial Assistance Program states to be eligible for assistance through the TBFA Program, a person must be:

- A NH resident living with active TB, suspected active TB or LTBI;
- Be under a physician's care for TB, and have a physician's or designee's prescription for one or more of the drugs claimed under this program; and
- Have an annual gross household income that does not exceed 200% of the Federal poverty income guidelines. If the applicant's annual gross income is greater than 200% of the allowed income in the Federal poverty income guidelines, the difference shall be multiplied by 80% in order to determine the amount of out-of-pocket dollars that shall be spent on medical care before the applicant is eligible. Qualifying expenditures will be defined by Medicaid policy.