SMS Financial Assistance (optional service requested)

S MS offers financial assistance to help with some medical bills. Assistance is after all other insurance and resources have been exhausted. Eligibility for assistance is determined using HH income and resources. Payments made are at NH Medicaid rates and must support/be related to the applicants medical diagnosis .

Applicants Name ______________________ Date ____________ SMS Case # ____________

Name Of HH	**Applicant**	**Parent/Guardian 1**	**Parent /Guardian 2**
Name of person whose income you are reporting:			
Gross Earned Income (Monthly Total)	Provide Verification or written statement to support information as reported		
Employed; Total gross amount of the last /current month of pay (weekly~ 4 pay stubs or Bi-weekly ~2 pay stubs) **OR**			
Self Employed; Last Year's 1040 Tax Form; Schedule C			
Unearned Income (Monthly Total)	Provide Verification or written statement to support information as reported		
Social Security/Disability (SSI/SSA)			
Child Support/Alimony Received/Rental Income			
Unemployment Compensation (Copy of check)			
Cash Assistance (i.e. TANF /FAP/APTD/ANB)			
Pension/VA Benefits			
Dividends/Interest (trust/annuities /settlement)			
Current Balance of Accessible Resources			
Checking Accounts			
Savings			
Stocks/Savings Bonds /CD's/Mutual Funds			
Trust Funds (copy is required except if Special Needs Trust)			
Expenses	Provide Verification or written statement to support information as reported		
Health or Dental Insurance Premiums:			
Court Ordered Child Support (Paid to someone outside the HH)			
Household Child Care Expenses (Monthly Cost)			
Specialty Diet Foods for Medical Condition			

Please Sign: ____

The applicants signature above shall attest that all information provided in the application is true and correct to the best of my knowledge I realize that any intentional misrepresentation may result in legal action against me since special medical services receives its funds from state and federal sources. I also realize the SMS may use other state data or resources to verify the information provided in this application.

HEALTH CARE EXPENSES

Expenses can be used as a deduction in the determination of financial assistance for this application.
ANY PAID or OWED health care expenses incurred by any member of the family that resides in the same household as the applicant that have a date of service no more than 1 year from the date of application.
Do not include bills that have been or will be paid by your employer, health insurance, Medicaid or any other source/agency.

Service was for (Name)	**Date of Service**	**Type of Service** Dental~ Hospital ~ Medications ~ Office Visit~ Medical Supplies	**Total of Billed Amount**	**Amount Paid by You**	**Date Paid**	**Remaining Balance Owed By You**

If you need more room continue on a blank page.

As a reminder any bills that are used above as a deduction to become eligible for financial assistance will not be paid by SMS and will remain your responsibility to make arrangements for payment. These bills may also only be used and submitted one time