HEALTHFIRST
"Health care for the whole family"

Discount Program Application

☐ 841 Central Street Franklin, NH 03235
(603) 934-1464

☐ 22 Strafford Street Laconia, NH 03246
(603) 366-1070

Patient Information

Name:_____

Physical Address:_____City:_____State/zip:_____

Mailing Address (if different than above):_____

Home #:_____Cell#:_____Work#:_____

Household Income

Please indicate all people living in the household, including applicant:

Name	Relationship to patient	Date of Birth	Monthly income	*Source of income
1)_____	**Self**	_____/____/____	$_____	_____
2)_____		_____/____/____	$_____	_____
3)_____		_____/____/____	$_____	_____
4)_____		_____/____/____	$_____	_____
5)_____		_____/____/____	$_____	_____

Documents requested

Please return completed application along with copies of **8 weeks ALL current income** for all adults listed above.

Copy of last **years Federal Income tax return including schedule C** if you are self employed.

Unearned income such **as unemployment, social security and or child support, alimony, real estate rental income, retirement account distributions and any other source of income**.

Copy of **Notice of Decision from Department of Health and Human Services,** if you are receiving any assistance, food stamps etc.

Patients may request a "Income –Self Employment or Declaration Form" which can substitute for all requested documents.

Applicant Signature: _____Date:_____

Co-Applicant Signature: _____Date:_____

Do you have health insurance? ☐ Yes ☐ No Insurance with large deductible? ☐ Yes ☐ No Amount $_____

Medicaid spend down? ☐ Yes ☐ No Amount: $_____

Medicare ☐ A ☐ B ☐ A&B Are you a Veteran? ☐ Yes ☐ No Are you a US citizen? ☐ Yes ☐ No

Have you applied for the Premium Assistance Program through DHHS? ☐ Yes ☐ No