



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 **ALL current income documents** 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