

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: 1-800-351-1888 EXT. 4495
OR DIRECTLY AT (603) 271-4495
FAX#: (603) 271-7985

FIRST APPLICATION

DATE: _____

NAME: _____ DATE OF BIRTH: _____
Last First MI

ADDRESS: _____ TELEPHONE: _____

_____ COUNTY: _____
City State Zip

SOCIAL SECURITY NUMBER: _____ MALE: _____ FEMALE: _____

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

NUMBER OF CHILDREN LIVING WITH YOU: _____ AGES: _____

REFERRED BY: _____

NAME AND LOCATION OF ONE PHARMACY TO BE USED: _____

HEALTH INSURANCE:

A. MEDICARE (PLEASE COPY FROM YOUR CARD)

CLAIM NUMBER: _____

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: _____

DISTRICT OFFICE: _____

C. OTHER HEALTH INSURANCE (SUCH AS BC/BS, METROPOLITAN, PRUDENTIAL, MEDICOMP, ETC.)

NAME OF COMPANY: _____

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**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.

**INCOME:**

PLEASE PROVIDE VERIFICATION OF INCOME CURRENTLY RECEIVED. PLEASE ATTACH A PHOTOCOPY OF YOUR SOCIAL SECURITY STATEMENT, MOST RECENT BANK STATEMENT, ETC., TO THIS APPLICATION.

APPLICANT'S GROSS INCOME: \_\_\_\_\_ / YEAR

\_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_ / MONTHLY

\_\_\_\_\_ PAYCHECK FROM JOB: \_\_\_\_\_ / MONTHLY

\_\_\_\_\_ SELF EMPLOYMENT WAGES (IF APPLICABLE) \_\_\_\_\_ / MONTHLY

\_\_\_\_\_ OTHER (PENSION, VA, CHILD SUPPORT, ETC.) \_\_\_\_\_

STOPPED WORKING DATE: \_\_\_\_\_

SPOUSE'S GROSS INCOME: \_\_\_\_\_ / YEARLY

MONEY COMES FROM: \_\_\_\_\_

OTHER INCOME: \_\_\_\_\_ SAVINGS: \_\_\_\_\_

INVESTMENTS: \_\_\_\_\_ IRA: \_\_\_\_\_

**MEDICAL HISTORY:**

ACTIVE DIAGNOSIS (ILLNESS FOR WHICH TREATMENT IS BEING RECEIVED): \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOW LONG HAVE YOU BEEN UNDER PHYSICIAN'S CARE: \_\_\_\_\_

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.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_