

Lamprey Health Care Financial Assistance Application

If you have no income sign here. Signature: _____ I hereby declare that I do not receive any income from any source.

Please explain how you are paying expenses:

**To process your application you must supply one of the following proofs of income:
4 Current consecutive pay stubs, unemployment check stubs, IRS tax return, or if Self- Employed
Schedule C**

**After June 30, if you are self employed or do jobs for cash, you must fill out a profit and loss form or
a cash for jobs form that can be picked up at the front desk or call if you need one mailed to you.**

Current estimate of MONTHLY income for all Family Members:

Your Monthly Salary, before taxes:	\$	Welfare Check:	\$
Spouse's Monthly Salary, before taxes:	\$	Child Support:	\$
Social Security Check:	\$	Alimony:	\$
Business Income:	\$	Disability Payments:	\$
Unemployment Check:	\$	Rental Income:	\$
Retirement Income:	\$	Other:	\$
TOTAL MONTHLY INCOME:	\$		\$

How many family members are supported by the reported income?

ALL INCOME LISTED MUST HAVE PROOF ATTACHED

Please list any special needs or circumstances that accurately reflect your financial situation:

* Monthly Cost of Prescription Medicine \$ (please list)

* Monthly Payments for Medical Bills (do NOT include insurance premiums) \$ (please explain)
(payment plan amount)

* Monthly Dental Payments (do NOT include dental premiums) \$ (please explain)

* Monthly Legal Payments \$ (please explain)

LAMPREY
HEALTH CARE
Where Excellence and Caring go Hand in Hand
205 South Main Street
Newmarket, NH 03857

***IF APPLYING FOR THE MEDICATION ASSISTANCE PROGRAM
YOUR LAST INCOME TAX FORM IS REQUIRED***

To Whom It May Concern:

Please be advised that I give Lamprey Health Care permission to sign my application(s) for the Medical Assistance Program (MAP) service they provide.

Signature

Printed Name

Date