



## 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:               | \$        |
| <b>TOTAL MONTHLY INCOME:</b>           | <b>\$</b> |                      | <b>\$</b> |

**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)

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

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

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\* Monthly Legal Payments \$ (please explain)

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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.

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Signature

Printed Name

Date