Concord Imaging Center
Business Office
2 ½ Beacon Street, Suite 199
Concord, NH 03301
(603) 228-1521

Re: Financial Assistance Application

Dear Applicant:

Please complete the enclosed application to its entirety and return it to the address listed above with a copy of your most recent pay stub, form W-2 and Federal Tax Return within 30 days of the date of this letter.

Please also enclose a minimum payment of $25 to keep your account active and avoid transfer to the collection agency.

You will receive a determination in writing within 30 days of receipt of your completed application.

Concord Imaging Center Billing Office
2 ½ Beacon Street
Concord, NH 03301
(603) 228-1521

CONCORD IMAGING CENTER: FINANCIAL ASSISTANCE APPLICATION

Please note: All application information will be kept confidential.

PART I: Personal Information

Concord Imaging Center Account #: (as shown on your bill) _____

Patient Name: _____
Address: _____
City/State/Zip: _____
How long have you lived at the above address: _____
Telephone #: ( ) _____
Social Security #: _____
Previous Address: _____
City/State/Zip: _____
How long had you lived at the above address: _____

Spouse/Guardian: _____
Relation to Patient: _____
Spouse/Guardian Address: _____
City/State/Zip: _____
Spouse/Guardian Telephone #: ( ) _____

Patient's Employer Name: _____
Patient's Employer Address: _____
City/State/Zip: _____
How long have you been employed at this employer? _____

Spouse/Guardian Employer Name: _____
Spouse/Guardian Employer Address: _____
City/State/Zip: _____
How long have they been employed at this employer? _____

Patient's Former Employer Name: _____
Patient's Former Employer Address: _____
City/State/Zip: _____
How long were you employed at this employer? _____

Spouse/Guardian's Former Employer Name: _____
Spouse /Guardian's Former Employer Address: _____
City/State/Zip: _____
How long were they employed at this employer? _____

Dependent Information

Name of Dependent	Relationship to Patient	Age	Living with the Patient (YES or NO)

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PART II: Financial Information

HOUSEHOLD INCOME SUMMARY

	Monthly Amount Net of Taxes
Patient's Wages:	
Spouse/Guardian Wages:	
Pensions:	
Child Support:	
Alimony:	
Income from Federal or State Assistance Programs:	
Other Income:	
Total Household Income:	

HOUSEHOLD EXPENSE SUMMARY

	Monthly Amount Paid/Due
Telephone:	
Electricity:	
Heat:	
Medical Expenses:	
Food:	
Other Expenses:(please describe)	
Insurances:(dental, health, life, other)	
Real Estate Taxes:	

DO NOT INCLUDE ANY EXPENSES PAID THROUGH ESCROW IN THE ABOVE AMOUNTS

ASSET SUMMARY

		Monthly Amount Paid/Due
Real Estate Owned:	Please Describe:	Rent:
		(please state to whom you pay rent):
Current Appraised Value:		Mortgage:
Location of Real Estate Owned		(Please state to what bank you pay your mortgage):
Vehicle Owned:	Please Describe:	Vehicle Loan:
	(make and model)	(Please state to what bank you pay your vehicle loan to):
Blue Book Value of Vehicle Owned:		

Other Assets Owned:

Description	Current Value

Other Debts:

(ie: credit cards, home equity loans, lines of credit, second mortgages etc.)

Description	Monthly Payment

Total Household Expenses:

Bank Accounts:

	Bank Name	Current Balance
Current Checking Account:		
Current Savings Account:		
Current Money Market:		
Other Investments:		

CONCORD IMAGING CENTER: FINANCIAL ASSISTANCE APPLICATION

Please note: All application information will be kept confidential.

I attest that the information provided in this application is current and correct and understand that Concord Imaging Center may conduct a credit check for further information.

Patient Signature: _____ Date: _____

Spouse/Guardian Signature: _____ Date: _____

DO NOT WRITE BELOW. OFFICE USE ONLY.

Decision: Determined By:

_____ _____

Date