

Accessible Resources	Please attach copies of appropriate paperwork to support information as reported	
Trust funds/Settlements		
Checking Accounts		
Savings Accounts		
Stocks / Savings Bonds / CD's		

By my initials, I declare that these financial statements are correct and true to the best of my knowledge. I realize that any intentional misrepresentation may result in legal action against me since The Catastrophic Illness Program receives its funds from state and federal sources. _____(Initials)

Do you have any form of health insurance? Yes / No

Private Insurance: Yes / No / Cobra **Name of Insurance:** _____ **Monthly Premium:** _____

Medicare (Check All That Apply): Part A Part B Part D **Monthly Premium:** _____

Medicaid: Yes / No **Type of:** APTD HC-BC OAA **Date Applied For:** _____

Do You Have A Monthly Spend-Down? Yes / No **Monthly Amount:** _____

Veterans Benefits: Yes / No

Medical Information:

What are your current and active diagnoses? _____

Who referred you to the CIP Program? _____

Types Of Providers Treating Your Diagnosis	Name	Office Name & Address	Telephone
Primary Care Provider			
Specialist			
Other Treating Doctor			
Other Treating Doctor			
Social Worker			
Pharmacy Used			

~You have completed the CIP Application~ please sign below.

Print name of who filled out the application: _____

Signature of Applicant: _____ Date: _____

By signing my name, I attest that all information provided in the application is true and correct to the best of my knowledge.

Mail completed application to: DHHS/ BEAS Catastrophic Illness Program, 129 Pleasant St, Brown bldg, Concord NH 03301

OFFICE USE ONLY

CIP Case Number				Program Code:
Income Verification	NEED	HAVE	REQUESTED	Financial Review By:
Resource Verification	NEED	HAVE	REQUESTED	Medical Review By:
HIPPA Release	NEED	HAVE	REQUESTED	Letter Sent: