



**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF COMMUNITY BASED CARE SERVICES**

*BUREAU OF ELDERLY & ADULT SERVICES*

*CATASTROPHIC ILLNESS PROGRAM*

129 PLEASANT ST, CONCORD, NH 03301-3857  
603-271-4495 1-800-351-1888, Ext. 4495  
Fax: 603-271-7985 TDD Access: 1-800-735-2964

Nicholas A. Toumpas  
Commissioner  
  
Nancy L. Rollins  
Associate Commissioner

April 12, 2010

**RE:**  
**DOB:**

Dear \_\_\_\_\_ :

The above-named client has applied for assistance through the New Hampshire Catastrophic Illness Program. This program offers financial assistance **ONLY** to individuals requiring active medical treatments for specific medical conditions. These medical conditions are: Cystic Fibrosis, Cancer, Hemophilia, Spinal Cord Injury with resultant non-ambulation, End Stage Renal Disease, and Multiple Sclerosis.

**Please state his/hers active illness here:** \_\_\_\_\_

**Date of Diagnosis:** \_\_\_\_\_

**Medications and/or supplies are the following** \_\_\_\_\_

In order for us to determine his/her medical eligibility, we require a verification of ongoing treatment of one of the above diagnoses. **Please submit that last office visit note.**

**An applicant with a cancer shall be considered eligible if he or she is:**

**1.) Has undergone active cancer treatment within the last 12 months, defined as undergoing chemotherapy or radiation treatment or cancer surgery: and**

Please answer Yes or No: \_\_\_\_\_

**2.) Requires oncology monitoring post-active treatment, up to 5 years after undergoing active cancer treatment.**

Please answer Yes or No: \_\_\_\_\_

I certify this patient has one of the above catastrophic diagnoses.

Physician Signature: \_\_\_\_\_

(PRINT NAME AND ADDRESS CLEARLY) \_\_\_\_\_

Enclosed you will find a Release of Information. Thank you for your kind cooperation in this matter.

Sincerely,

Richard St. Onge  
Financial Manager  
Catastrophic Illness Program

RSt.O:lab  
Enclosure HIPPA Release