

FINANCIAL ASSISTANCE APPLICATION

All healthcare facilities are required to provide medically necessary care, without charge, to eligible person. To be eligible, an individual must:

1. Be a resident of the State of Michigan
2. Not be currently receiving Medicaid benefits
3. Be a person or from a family whose income is at or below the federal income poverty guidelines

Even if you are not eligible for free care through the State of Michigan program you may still be eligible for a discount on healthcare services through the financial assistance program. You may qualify for this program if your income is at the Federal Poverty Guidelines even if you are not a resident in Michigan, or if you are medically indigent.

If you wish to apply, please complete the family size/income section below filling in all spaces completely
ALL SPACES NEED TO BE COMPLETED FOR APPLICATION TO BE ACCEPTED

Patient/Guarantor Information _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Do you have health insurance? yes no Are you on active disability? yes no

If you have health insurance please attach copy of insurance card to application.

In order to process your application you must attest to your total income for the 3 or 12 months prior to the date of service for the following types of income. Please indicate if the income is for 3 months or 12 months.

PLEASE INCLUDE A COPY OF YOUR BILLING STATEMENT AND RETURN ALL INFORMATION WITHIN 30 DAYS.

Wages, Bonuses	Farm Or Self Employment	Pensions	Public Assistance
Tips, Social Security	Workers Compensation	Strike Benefits	Unemployment Compensation
Alimony, Child Support	Military Allotments	Tax Returns	Interest, Dividends, Rents

Please submit at least two documentations to support the income information attested to below. Please give the following information for the patient, spouse and all of the patient's children, natural or adoptive, under the age of 18 living in the home for which the patient is legally responsible.

NAME	DATE OF BIRTH	RELATIONSHIP TO YOU <small>self / spouse / child</small>	SOCIAL SECURITY NUMBER	INCOME PRIOR TO DATE OF SERVICE <small>___ 3 calendar months ___ 12 calendar months</small>

If you list your income as \$0 please provide information regarding your living situation/means of support below.

This document is legal and binding. Your signature below attests that to your knowledge the information provided is current and accurate.

Signature _____ Date _____ Must be signed and dated to be valid.