FINANCIAL ASSISTANCE PROGRAM

APPLICATION

- The Financial Assistance Program provides patients with discounts off covered services for those who qualify.
- Please complete, sign, and date the attached Financial Assistance Application with the required income verification documents and fax or return to the location where services are/will be provided.
- Your completed Application will be reviewed for a discount up to 100% of total charges (excluding any applicable co-pays).
    - *Financial Assistance Program co-pays are not subject to further discounting and are as follows:*
        - *Outpatient Treatment/Diagnostic Testing* *$ 5.00*
        - *High Dollar Diagnostic Testing/Urgent Care Services* *$25.00*
        - *Outpatient Surgery/Emergency Room Care or Inpatient Stay* *$50.00*
    - ***Note: Copays do not apply to physician office visits***
- If you are not eligible under the Financial Assistance Program and are uninsured you will automatically receive an uninsured discount off of all covered medical services (excludes cosmetic or elective services).

ELIGIBILITY

In order to qualify for eligibility under the Financial Assistance Program, you may be required to submit all or part of the following:

- A copy of your last year's tax return
- Copies of current pay stubs, if applicable
- Additional documents to validate income from other sources; examples include, but are not limited to: child support, alimony, workers compensation, public assistance, self-employment income, unemployment income, etc.
- All household income and residents should be represented on your application, including verification of residency and income sources.
- During the eligibility review process, if it is determined that eligibility under an alternative funding source is available, you may be required to complete an application for the alternate program before consideration under the Financial Assistance program; example: Application for Medicaid Assistance, Uninsured Motorists, etc.

Please Note: ***Failure to cooperate and pursue coverage eligibility for other programs (i.e., Medicaid, Disability, Personal Injury Claim, Workers Compensation, Uninsured Motorist, etc.) may result in the denial of eligibility for the Financial Assistance Program.***

FINANCIAL ASSISTANCE IS NOT AVAILABLE FOR:

- Most Co Pays, deductibles and co-insurance.
- Personal items, such as telephone and television expenses.
- Services that are not medically necessary including elective procedures, cosmetic procedures and infertility treatments
- Services covered by insurance in another health care network.

ASSISTANCE

If you have questions regarding the Financial Assistance Policy, need assistance completing the Financial Assistance Application, or need the correct mailing address for submission of your completed application please use the information below:

Facility/Health System Where Services Are/Will Be Provided	Financial Counselor	Customer Service	Financial Counselor Fax No.	Mailing Completed Applications To:
Genesys Health System	810-606-7431	888-544-7737	810-606-7897	Patient Access/Financial Counseling Dept. One Genesys Parkway, Grand Blanc, MI 48439
St. Mary's of Michigan – Saginaw	989-907-7585	888-978-6279	989-907-7765	Financial Counseling Dept. 4599 Towne Centre Rd. Saginaw, MI 48604
St. Mary's of Michigan – Standish Hospital	989-846-3586	888-978-6279	989-846-3541	Financial Counseling Dept. 805 W. Cedar St., Standish, MI 48658
St. Joseph's Health System – Tawas	989-984-3796	877-216-5873	989-362-2106	Financial Counseling Dept. 200 Hemlock, Tawas City, MI 48764
Ascension Medical Group Physician *Genesys*	844-701-9988	844-701-9988	512-324-8962	N.R.S.C – Financial Assistance Dept. 4616 West Howard Lane, Suite 850 Austin, Texas 78728
Ascension Medical Group Physicians *St. Mary's, Standish and St. Joseph's Health System Providers*	800-566-5050	800-566-5050	317-583-2753	N.R.S.C – Financial Assistance Dept. 10330 N Meridian St., Suite 200 Indianapolis, IN 46290

If you are submitting (faxing) financial or other information to be used for eligibility consideration, please be sure to write the patient's name, date of birth and account number (if applicable) in the upper right hand corner of each faxed page.

Thank you for entrusting us with your health care needs

GENESYS ST. MARY'S OF MICHIGAN ST. JOSEPH HEALTH SYSTEM ST. MARY'S OF MICHIGAN STANDISH HOSPITAL

FINANCIAL ASSISTANCE PROGRAM APPLICATION

PATIENT INFORMATION (PLEASE PRINT) **Account No.**

Patient Name:	Birth Date	Marital Status	Sex		Telephone No.
Address:	City	State	Zip		Email Address
Social Security Number:	Employer		Full Time Part Time		How many hrs/wk
Employer Address:	City	State	Zip		Telephone No.

RESPONSIBLE PARTY'S INFORMATION

Name Same as above	Birth Date	Marital Status	Sex		Telephone No.
Address		State	Zip		Email Address
Social Security Number	Employer		Full Time Part Time		How many hrs/wk
Employer Address	City	State	Zip		Telephone No.

RESPONSIBLE PARTY SPOUSE INFORMATION

Spouse's Name		Social Security Number		Birth Date
Spouse's Employer:	Address:	City State Zip		Telephone No.

DEPENDENTS:

Name	Age	Relationship	Name	Age	Relationship

ASCENSION HEALTH

GENESYS ST. MARY'S OF MICHIGAN ST. JOSEPH HEALTH SYSTEM ST. MARY'S OF MICHIGAN STANDISH HOSPITAL

GROSS MONTHLY INCOME	
Applicant Earned Income	
Applicant Spouse's Income	
Social Security Benefits	
Pension/Retirement Income	
Unemployment Compensation	
Worker's Compensation	
Interest / Dividend Income	
Child Support	
Alimony	
Rental Property Income	
Food Stamps	
Other	
Other	
TOTAL GROSS INCOME:	$

ASSETS	
Cash on Hand	
Savings Account	
Checking Account	
C.D.'s	
Securities	
Life Insurance	
Other Real Estate	
Other	

Vehicle / M	Year	Value

Financial Settlements:	
Life Insurance	
Inheritance	
Other	
TOTAL VALUE OF ASSETS:	$

MONTHLY LIVING EXPENSES	Payment	Balance
Mortgage/Rent		
Electricity		
Gas		
Telephone		
Water		
Groceries		
Cable TV		
Car Payment		
Cell Phone		
Day Care		
Child Support/Alimony		
Prescription Drugs		
Credit Cards:		
1.		
2.		
3		
Other Doctor / Hospital Bills:		
Insurance Expense:		
1. Automobile		
2. Property		
3. Medical / Life		
Other Loan Payments:		
1.		
2.		
Other Monthly Payments:		
cobra		
life insurance		
3.		
TOTAL MONTHLY EXPENSES:	$	$

COMMENTS:

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative

ASCENSION HEALTH

FINANCIAL ASSISTANCE PROGRAM APPLICATION CERTIFICATION

My signature on this form certifies that all of the statements and information provided in the Financial Assistance Program application are true and accurate to the best of my knowledge and that I have disclosed all facts concerning my finances. I understand and acknowledge that any misrepresentation of any information submitted on this application or failure to cooperate with efforts to qualify me for other programs which may cover the cost of my care (for example, Medicaid, Personal Injury Claim, Workers Compensation, Uninsured Motorists, etc.) may result in denial of my eligibiity under the Financial Assistance Program and I will be financially liable for the services provided. I agree to allow authorized hospital/provider representatives to request and review a report of my credit and to take other reasonable steps to verify and validate all information provided in this application. I understand that if I qualify for discounts of less than 100% I will be responsible for payment of the remaining portion of my bill(s).

Patient/Responsible Party Signature: _____ ***Date:*** _____

LACK OF INCOME CERTIFICATION (ONLY COMPLETE IF APPLICATION IS SUBMITTED WITH ZERO INCOME)

I am currently unemployed and have no source of income. My living expenses are being paid by and provided for as follows:

Signature: _____ ***Date:*** _____

To be completed by Financial Assistance Program Administrator Only

Income/Dependent/Expense Verification	
Total Income Verified (all sources)	
Total Dependents Verified	
Total Expenses Verified	

Method Used for F.A.P. Eligibility Determination (circle all that apply)	
√	Means Test
√	Presumptive – Type of Presumptive:
√	Sliding Scale

Other Consideration in F.A.P. Eligibility Determination

F.A.P. Eligibility Determination/Status	
□ Approved	Discount %:
□ Pended	Reason:
□ Denied	Reason:
Evaluation and Determination Completed By: Name:	***Telephone:***

F.A.P. Determination Notification	
Date Applicant Was Notified:	
F.A.P. Applicant Notification Method	
□	Notified By Telephone - Name of person notification was provided to:
□	Notified by U.S. Mail (Copy of letter maintained on file)
□	Notified Other Method: Describe:
Notification Completed By: Name:	***Telephone:***

F.A.P. Account Processing			
Account No.	**Amount Processed/Adjusted**	**Account No.**	**Amount Processed/Adjusted**
Date:	***Processed/Adjusted By: Name:***		***Telephone:***