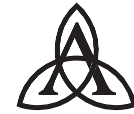
# Financial assistance application form



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## Patient information

*(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)*

Date________________________________ Account number ______________________ Hospital Name ___________________________________

Name (first and last)________________________________________________________________

Birth date____________________________________ Marital status___________________ Phone number ________________________________

Mailing address_______________________________________________________ City____________________________ State_______ ZIP_______

Social security number (optional) ________________________________________________

Employer____________________________________________________________________ Employment status_____________________________

Number of hours worked per week____________________________ Employer phone number___________________________________________

## Responsible party's information/legal guardian's information

*(If patient above is same as responsible party, leave this section blank.)*

Name (first and last)________________________________________________________________

Birth date____________________________________ Marital status___________________ Phone number ________________________________

Mailing address_______________________________________________________ City____________________________ State_______ ZIP_______

Social security number (optional) ________________________________________________

Employer____________________________________________________________________ Employment status_____________________________

Number of hours worked per week____________________________ Employer phone number___________________________________________

## Responsible party spouse information

*(If patient is same as responsible party, fill in spouse information for patient.)*

Name (first and last)________________________________________________________________

Birth date____________________________________ Marital status___________________ Phone number ________________________________

Mailing address_______________________________________________________ City____________________________ State_______ ZIP_______

Social security number (optional) ________________________________________________

Employer____________________________________________________________________ Employment status_____________________________

Number of hours worked per week____________________________ Employer phone number___________________________________________

## Dependents of responsible party

*(If patient is same as responsible party, fill in spouse information for patient.)*

Name_______________________________________ Birth date___________________ Relationship to responsible party ___________________

Name_______________________________________ Birth date___________________ Relationship to responsible party ___________________

Name_______________________________________ Birth date___________________ Relationship to responsible party ___________________

Name_______________________________________ Birth date___________________ Relationship to responsible party ___________________

Number of adults and children living in household _________________________________

## Monthly income

*(Fill in dollar amounts for each item listed below. Provide amount per month for each.)*

Applicant earned income ___________________

Applicant spouse income ___________________

Social security benefits ___________________

Pension/retirement income ___________________

Disability income ___________________

Unemployment compensation ___________________

Worker's compensation ___________________

Interest/dividend income ___________________

Child support received ___________________

Alimony received ___________________

Rental property income ___________________

Food stamps ___________________

Trust fund distribution received ___________________

Other income ___________________

Other income ___________________

**Total gross monthly income $** ___________________

## Monthly living expenses

Mortgage/rent ___________________

Utilities ___________________

Phone (landline) ___________________

Cell phone ___________________

Groceries/food ___________________

Cable/internet/satellite tv ___________________

Car payment ___________________

Child care ___________________

Child support/alimony ___________________

Credit cards ___________________

Doctor/hospital bills ___________________

Car/auto insurance ___________________

Home/property insurance ___________________

Medical/health insurance ___________________

Life insurance ___________________

Other monthly expense ___________________

**Total monthly expenses $** ___________________

## Assets

Cash/savings/checking accounts ___________________

Stocks/bonds/investments/CD(s) ___________________

Other real estate/secondary residence ___________________

Boat/RV/motorcycle/recreational vehicle ___________________

Collector automobiles/non-essential automobiles ___________________

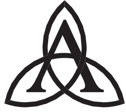
Other assets ___________________

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.

Signature of Applicant ___________________

Date ___________________

**Comments** ___________________



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# Letter of support

Patient medical record number/account number________________________________

Supporter's name________________________________________________________________

Relationship to patient/applicant ______________________________________________

Supporter's address ____________________________________________________________

To Ascension:

This letter is to advise that (patient's name)________________________________receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter________________________________

Date ________________________________

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**REQUIRED DOCUMENTATION & CERTIFICATION**

Along with the application, please provide a copy of at least one of the following items as your proof of income. If you are married or have lived with a significant other for 6 months or longer, they will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copy of Official Picture Identification – Driver's License or State ID or Valid Passport
- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Other income validation documents
- Copies of bank statements from last 3 months
- Copy of receipt of unemployment benefits

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, please also provide documentation as proof of your outstanding monthly medical and pharmacy/drug costs.

Please know that the completed application along with proof of income must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed.

We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

Please print and mail or hand deliver your completed application to the following address:

| Facility/ Office where services were/ will be provided | Mail Completed Application To: |
|---|---|
| Ascension Providence Rochester Hospital | 1101 West University Rd., Rochester, MI |
| Ascension Medical Group - Physician Services | PO Box 80278, Indianapolis, IN 46240 |

If you have any questions about this application, please call one of our Patient Representatives at (248) 652-5334.