FINANCIAL ASSISTANCE APPLICATION

Hospital: ______________________________ **Account Number:**_____________________

PATIENT INFORMATION

Patient Name: ____ **Birth Date:**_______________

Marital Status (circle): S M D W **Last 4 Digits of SSN**___________________________

Patient Address: ____

City/State/Zip: ____

Primary Phone: ______________________________ **Alternate Phone:**_________________

Spouse's Name: _____________________________ **Spouse Primary Phone:**______________

Medical Insurance: ____

Medical Insurance Application In Process*:____

RELATIVE/OTHER CONTACT INFORMATION TO CONFIRM FINANCIAL SUPPORT

Relative/Other Contact Name: ______________________**Relationship:**___________________

Primary Phone: __________________________ **Alternate Phone:**_______________________

EMPLOYMENT AND INCOME INFORMATION

Number of Taxable Dependents: ________**Number of children Aged 18 and Under:** _________

Patient's employer(s): ____

Hire Date: ________________________________ **Work Phone:**_____________________

Ave Hours Worked Weekly__________________ **Hourly Wage:**_____________________

Spouse's employer(s): ___________________________________ **Hire Date**: _____________

Ave Hours Worked Weekly__________________ **Hourly Wage:**_____________________

If you own a business or are self-employed, describe the business:

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Uninsured patients may be denied full charity if they are determined to be "non-cooperative" with attempts to obtain insurance or eligibility coverage through other programs (for example - Medicaid).

ASCENSION MICHIGAN

FINANCIAL ASSISTANCE APPLICATION

REQUIRED DOCUMENTATION & CERTIFICATION

In order to process your Financial Assistance Application, you must provide a copy of the following items:

Copy of Official Picture Identification – Driver's License or State ID or Valid Passport AND

Income Verification – (i.e., Current Pay Stub; Tax Return; Bank Statement and Current Amount:

- Alimony Received ____________________________
- Social Security Received________________________
- Unemployment Income_________________________
- Disability Received____________________________

Letter of Support – Signed by the party who is helping you with living and/or shelter support

CERTIFICATION

My signature on this form certifies that all the statements are true to the best of my knowledge and that I have disclosed all facts concerning my finances. I understand and acknowledge that any misrepresentation of my finances in connection with this Application, or any failure to cooperate with efforts to qualify me for programs which may cover the cost of my care (for example, Medicaid, personal injury claim, workmen's compensation, auto claims) may invalidate any award of Financial Assistance/Charity Care and that I will be financially liable for the services provided. I agree to allow St. John Providence Health System or its representatives to request and review a report of my credit and to take other reasonable steps to validate all information provided.

I understand that if I qualify for partial financial assistance/charity care I will be responsible for payment of the remaining portion of my bill.

Please Sign Below:

____

Print Patient Name / Guardian **(Date)**

____

Signature Patient / Guardian **(Date)**

Office Use ONLY

Financial Counselor Name:

FA Application Date: FA Application Term Date:____________________

____

Status: Approved/Denied Decision Date: Letter Sent/Date:

____

ACA discussed With Patient: Y/N F/U Call Requested: Y/N Best Time To Call

___________ ___________________

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