

- McLaren-Bay Region
- McLaren-Bay Special Care
- McLaren Cancer Institute
- McLaren-Central Michigan
- McLaren-Clarkston
- McLaren-Flint

Request For Financial Assistance

- McLaren-Greater Lansing
- McLaren Health Care
- McLaren Health Plan

- McLaren Homecare Group
- McLaren-Lapeer Region
- McLaren-Macomb
- McLaren Medical Group
- McLaren-Oakland
- McLaren-Orthopedic Hospital
- Northern Michigan Regional Hospital
- Other

Total of Balance(s) Due	_Acct. #'s			
Patient Name	Social Security	Number	DOB	
Home Address		City	State	Zip Code
Home Phone	Alternate Phone			
Name Responsible Party (Guarantor)		Social Security Number		DOB
Employer	Wo	ork Phone		
Please Check One: Actively Employed	l Self-Employed	Unemployed	Retired	Disabled
If Employed – are you working: Full-time Pa	rt-time Casual A	verage # hrs/Week		
Spouse's Name	Social Securi	ty Number	DOB	
Spouse Employer				
Please Check One: Actively Employed	l Self-Employed	Unemployed	Retired	Disabled
If Employed – are you working: Full-time Pa	rt-time Casual A	verage # hrs/Week		
Name and Age of Dependents (include self & spous	e)			

SAVINGS (CD, Money Market, IRA), Checking and Credit Union Accounts

Bank Name	City	Type of Account	Balance

If Yes, list below. Do you own your home? Yes No

Do you own any other property? Vehicles, RV's, other real estate Yes No If Yes, list below.

ASSETS	

Asset – Home, Vehicle, etc.	Market Value	Loan Amount Outstanding	

HOUSEHOLD MONTHLY INCOME AND EXPENSES

Income Item	Amount (Monthly)	Expense Item	Amount (Monthly)
Total Household Gross Pay		Rent/Mortgage	
Social Security Income		Property Taxes	
Interest Income		Automobile	
Rental Income		Insurance: Homeowners	
Alimony		Insurance: Automobile	
Child Support		Insurance: Health	
Pension		Insurance: Life	
General Assistance		Utilities	
Unemployment		Groceries	
State/Federal Assistance		Gasoline	
Contributions from Others		Medical	
Land Contract Income		Alimony/Child Support	
Worker's Comp		Other	
Military Family Allotments		Other	
Other (please specify)		Other	

INSTALLMENT LOANS AND CREDIT CARDS

Creditor	Balance Owed	Monthly Payment

Total Income	Total Expenses

Please attach any further details regarding your Income and Expenses that may be pertinent to your application.

I hereby affirm that the above information is correct to the best of my knowledge. I authorize McLaren Health Care Corporation (MHCC) and its subsidiaries to verify any information for completeness and accuracy. I further authorize such information to be available for release to MHCC and its affiliates. I understand that as a charitable organization, MHCC may provide me with discounted or free care. I further understand that a personal credit report may be obtained in the decision making process.

Patient or Responsible Party Signature

Date

Date

Spouse's Signature

Approvals are valid for six months, upon which updated information will be required for any future services. Agreeable payment arrangements must be made for any remaining balance and can be re-evaluated at MHCC's discretion.

APPROVED DENIED

ENTAL:

AUTHORIZED SIGNATURE

DATE

REASON FOR DENIAL: