

## CARO REGION

### **Financial Assistance Application**

Dear Patient / Guarantor:

Thank you for choosing McLaren Caro Region for your healthcare needs. We provide financial assistance for patients meeting eligibility requirements

**Incomplete application will not be processed.** The completed application including all documentation must be received for financial assistance consideration. Required documentation includes:

- Copy of Official Picture ID Drivers license or State ID
- Income Verification
  - A copy of your most current federal tax return including all schedules and W-2's
  - A copy of your most recent 3 pay stubs for anyone working in your household
  - Bank statements showing last 2 months of income
  - Medicaid Denial letter (when available)
- Other:\_\_\_\_\_

Mail completed application and supporting documentation to:

McLaren Caro Region Financial Assistance Dept P.O. Box 435 Caro MI 48723

If you have any questions, please contact our Patient Accounting Department at 989-672-5121. Monday through Friday 8:00 AM – 4:30 PM.

Respectfully, McLaren Caro Region



# **Financial Assistance Application**

### **Patient Information**

Patient Name :			Birth Date	
Marital Status: Single	_ Married	Separated	Divorced	Windowed
Patient Address:				
City / State / Zip				
Primary Phone #				
Health Insurance: No	Yes (plea	ase specify)		
Health Saving Account: N	loYes	(please specify	)	
Have you applied for Medicaid?			_(please attach copy of denial letter)	
Employer			Address	
Spouse Employer			Address	
Unemployed? How long	?			

	Members of Household		
	Name	Age	Relationship
1			
2			
3			
4			
5			
6			
7			
8			

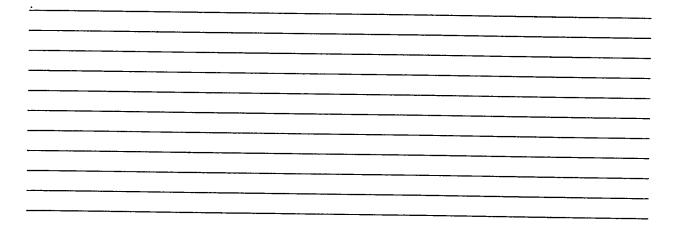
Monthly Income	Amount	Monthly Expenses	s Amount	
Monthlywene (man)				
Monthly wages (gross)		Rent / Mortgage		
Social Security Income		Property Taxes		
Interest Income		Automobiles		
Rental Income		Insurance: home		
Alimony		Insurance: auto		
Child Support		Insurance: health		
Pension		Utilities		
Unemployment		Phone		
State / Federal				
Assistance		Cable		
Workers Comp		Groceries		
Contributions from others		Gasoline		
Military Allotment		Medical		
		Alimony / Child		
Other (specify)		support		
Other (specify)		Other (specify)		
Total	\$	Total	\$	

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\_\_\_\_\_

Additional information or comments:



### **Required Documentation & Certification**

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

- Copy of Official Picture ID Drivers license or State ID
- Income Verification
  - A copy of your most current federal tax return including all schedules and W-2's
  - A copy of your most recent 3 pay stubs for anyone working in your household
  - Bank statements showing last 2 months of income
  - Medicaid Denial letter

• Other:\_\_\_\_\_

#### Certification

I certify that the facts contained in this financial assistance application are true and complete to the best of my knowledge.

I understand that this application is being completed so the McLaren Caro Region can make a judgement of my eligibility for a financial assistance discount based on a sliding scale program. If any information proves to be untrue, I understand that the hospital may re-evaluate my financial status and need for financial assistance. I agree to let McLaren Caro Region or its representative validate all information provided.

I understand that if I qualify for partial financial assistance, I will be responsible for the remaining portion of my bill.

Signature		
Date		
Do not write bel	low this line	
Account Number	Total Balance	
Finance Assistance %		
Approved Denied	Initials	Date
Reason		

FORM: FIN 11 REV: 7-30-19