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 989-673-5121. Monday through Friday 8:00 AM – 4:30 PM.

Respectfully,
McLaren Caro Region

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 #_________________________ Secondary Phone # _________________

Health Insurance: No _____ Yes (please specify)__________________________________

Health Saving Account: No_____ Yes (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		Amount
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		
Other (specify)				Alimony / Child support		
Other (specify)				Other (specify)		
Total		**$**		**Total**		**$**

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 below this line

Account Number ___________________ Total Balance___________________

Finance Assistance % ____________

Approved ________ Denied__________ Initials __________ Date _________

Reason____

____

FORM: FIN 11
REV: 7-30-19