



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



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			

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 _____