McLaren
HEALTH CARE

Financial Assistance Application Instructions

We will provide Financial Assistance for Medically Necessary services for patients who qualify.

Qualification for financial assistance will be based on the Federal Poverty Guidelines (published annually in the Federal Register). Patients who indicate that they do not have insurance or any other means of paying for medically necessary services may request consideration for Financial Assistance.

Patients applying for financial assistance MUST apply for all assistance through federal, state and local government programs (Medicaid, County Health Plans, Etc…) and provide proof of application and/or program denial to McLaren Health Care.

PLEASE RETURN THE FOLLOWING DOCUMENTS:

- **COMPLETED FINANCIAL ASSISTANCE APPLICATION** (incomplete ones will not be considered)
- **PROOF OF HOUSEHOLD INCOME** (LAST 2 CHECK STUBS, BANK STATEMENT OR OTHER PROOF)
- **INCOME VERIFICATION FORM** (IF YOU CURRENTLY DO NOT HAVE ANY INCOME)
- **COPY OF LAST FILED TAX RETURN**
- **PLEASE NOTE IF ANY DOCUMENTATION IS UNATTAINABLE**

McLaren Health Care may request additional financial documents necessary to process the Financial Assistance Application.

PLEASE RETURN THE COMPLETED APPLICATION AND SUPPORTING DOCUMENTS WITHIN FOURTEEN (14) DAYS TO:

McLaren Corporate Services
Attn: Revenue Cycle Operations
50820 Schoenherr Rd.
Shelby Township, MI 48315

If you have any questions or need assistance completing the application please contact:
Patient Financial Services
Customer Services Department
(844) 321-1557

McLaren HEALTH CARE

Income Verification Form

This form should only be used when the applicant for Financial Assistance lists no income.

All fields on this form must be completed for the form to be valid.

Applicant Name:	Applicant Current Address:

Applicant Income Verification
I, _____, certify that I have no earned or unearned income. I give McLaren Health Care permission to verify this statement. I understand that if McLaren Health Care finds that I have earned or unearned income, I will be disqualified from receiving financial assistance. I am currently being supported by (list how you are meeting basic expenses, food, clothing, shelter, including the names of all individuals providing support): _____ _____ _____ _____ _____ I understand that a representative from McLaren Health Care may contact the individuals listed above to verify the information provided.

Signature
Applicant Signature: _____ Printed Name: _____ Date: _____

McLaren HEALTH CARE

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

Request For Financial Assistance

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 _____ Work Phone _____

Please Check One: ❑ Actively Employed ❑ Self-Employed ❑ Unemployed ❑ Retired ❑ Disabled

If Employed – are you working: ❑ Full-time ❑ Part-time ❑ Casual Average # hrs/Week_____

Spouse's Name _____Social Security Number _____ DOB _____

Spouse Employer_____

Please Check One: ❑ Actively Employed ❑ Self-Employed ❑ Unemployed ❑ Retired ❑ Disabled

If Employed – are you working: ❑ Full-time ❑ Part-time ❑ Casual Average # hrs/Week_____

Name and Age of Dependents (include self & spouse)_____

_____

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

Bank Name	City	Type of Account	Balance

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

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

See Reverse Side…

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**

_____ _____

Spouse's Signature **Date**

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 ☐

_____ _____

AUTHORIZED SIGNATURE **DATE**

REASON FOR DENIAL: