HURON MEDICAL CENTER

Re: Application for Assistance

Thank you for expressing an interest in our Financial Assistance Program. Depending on your family income, you may be eligible for a discount up to 100% of the amount owed on your hospital bill. In order for us to determine if you qualify for a discount, or to determine a monthly payment plan if you do not qualify for a full discount, please complete the enclosed ***Application for Assistance*** and provide the following information:

- Most current pay stub showing year-to-date earnings for all working members of the household.
- Support for all other income, including, but not limited to, SSI or other government income, retirement, child support, alimony, food stamps.
- Most recent income tax return IF self-employed or clergy.
- Most recent Bank statement for all cash accounts, investments and IRA's representing at least 30 days activity.
- Apply for Medicaid and turn in your determination letter.

If you do not have any income, please provide an explanation as to how you support yourself and your family.
Failure to provide complete information may result in delay or denial of your application.
Please return your completed application and the information above to:
Huron Medical Center Patient Financial Services
1100 S. Van Dyke
Bad Axe, MI 48413
You will be notified of the determination of eligibility within 30 days of receipt of your application.
A copy of the hospital's financial assistance policy can be obtained from the hospital's website www.huronmedicalcenter.org or by calling the Financial Counselor and requesting a copy be mailed to you. If you have any questions concerning completion of the application or the required information, please do not hesitate to contact us. Patient Financial Services can be reached by calling 989-269-8933. Our hours are Monday through Friday from 8:00 am to 4:30 pm.

Sincerely,

Huron Medical Center
Patient Financial Services

HURON MEDICAL CENTER

APPLICATION FOR ASSISTANCE/MONTHLY PAYMENT PLAN

Patient or responsible party

name_____

Date of birth_____ Best phone number(s) to reach you _____

Best time of day to reach you: _____

List the names of all patients this application applies to: _____

_____

Please provide information below for all individuals living in the household (including your spouse or significant other) AND all persons you or your spouse are financially responsible for (continue on back of form if needed).

Name	Relationship	Age	Claim on income tax return (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total number of dependents claimed on the responsible party's income tax return _____

Other than the responsible party listed above, is there anyone else financially responsible for or required to carry health insurance for the patient? If yes, please provide their name, address and telephone number on the back of this form. Yes _____ No_____

Responsible Party Employment Information

Employer _____

Address _____

Occupation _____ Health Insurance offered Y/N_____

How long employed _____ Hours/week _____ Gross pay/week _____

Spouse or Other Household Employment Information

Employer _____

Address _____

Occupation _____ Health Insurance offered Y/N_____

How long employed _____ Hours/week _____ Gross pay/week _____

HURON MEDICAL CENTER

Include income for all members of household. Use back of form if necessary.

Other Source(s) of Income

Other sources of income include, but are not limited to**, unemployment benefits, social security payments, investment income, rental income, child support, food stamps, or any other income received.**

Source _____ Monthly Amount $_____

Source _____ Monthly Amount $_____

Source _____ Monthly Amount $_____

Banking & Asset Information

Bank/Financial Institution _____

City _____ Acct # _____ Balance _____

Bank/Financial Institution _____

City _____ Acct # _____ Balance _____

Cash value of stocks/bonds _____Money Market accounts _____IRA_____

Other than your primary residence and primary vehicles, please indicate any other assets you own not previously listed:

_____

_____

_____

Indicate on the back of this form any additional information you feel will be helpful to us in determining your eligibility for assistance or a payment plan.
Authorization (Your signature is required before we will process your application)

I do hereby believe this to be a true and complete representation of my income and financial situation as of the date indicated below. I understand that the Hospital may be requesting a credit report to verify the above information.

Signature of Responsible Party _____ Date _____

If you need help completing this form, or if you have any questions, please contact Patient Financial Services by calling 989.269.8933. Office hours are Monday through Friday, 8:00am to 4:30pm.