HILLSDALE HOSPITAL

Caring. Commitment. Community.

FINANCIAL ASSISTANCE APPLICATION

Patient(s) name: _____

Date of birth: _____

REQUIRED DOCUMENTATION CHECKLIST

- ☐ Copy of Drivers License
  - Patient, responsible party and spouse
    - ☐ Not applicable
- ☐ Copy of last three paystubs
  - Responsible party and spouse
    - ☐ Check if no paystubs for the household
- ☐ Copy of any other household income
  - Social Security benefits statement, disability reward letter, pensions, child support, etc.
    - ☐ Not applicable
- ☐ Copy of most recent W-2
  - Responsible party and spouse
    - ☐ Not applicable
- ☐ Copy of most recent income tax return
  - It is important to provide the **entire** tax return
  - Please provide a copy of the income tax return for patient or responsible party
    - ☐ Check if patient, responsible party, or spouse, does not file income taxes
- ☐ Copy of most recent bank statements
  - Responsible party and spouse
  - **All** bank statements are required – even those with a zero or negative balance
    - ☐ Not applicable
- ☐ Recent Medicaid decision letter
  - All applicants must either apply for Medicaid or prove ineligibility
  - Apply online at www.michigan.gov/mibridges
  - You may also contact our Medicaid Specialist at (517) 437-1723 for help with:
    - Applying for Medicaid
    - Proving eligibility or ineligibility
- ☐ Completed, dated, and signed application

RESPONSIBLE PARTY INFORMATION

Name:	Date of Birth:	SSN:
Address:		Phone:
Employer:	Monthly Gross Income: $	
Employer Address:		Phone:

SPOUSE INFORMATION

Name:	Date of Birth:	SSN:
Employer:	Monthly Gross Income: $	
Employer Address:		Phone:

PLEASE LIST ALL OTHER HOUSEHOLD INCOME (Social Security, Child Support, Pension, Etc.)

Name:	Source:	Amount:	Frequency:
		$	
		$	
		$	
		$	

PLEASE LIST EVERYONE IN YOUR HOUSEHOLD

Name:	Date of Birth:	Relationship:	SSN

Do you have a checking account?	Yes	No
Do you have a savings account?	Yes	No
Did you have health insurance on the date of service?	Yes	No
Have you applied for Medicaid within the last year?	Yes	No
Do you have a Medicaid Spendown/deductible?	Yes	No
Have you been approved for Food Stamps?	Yes	No
Are you homeless?	Yes	No
Do you have any additional real estate, besides home residence?	Yes	No
Estimated value: $	Address:	
Approximate amount of cash on hand?	$	

I hereby submit the above statement for the purpose of allowing Hillsdale Hospital to evaluate my financial status and determine my eligibility for various financial assistance programs, in order to receive discounted care on accounts within the last 270 days. I also hereby authorize Hillsdale Hospital to verify this information, as necessary. This may include a credit bureau report, employment and/or income verification, and appropriate supporting documents.

I attest that the above information, and all income documentation provided, is complete and accurate, as shown. I realize that should any of this information prove to be false, all Financial Assistance grants awarded will be reversed, and I will accept responsibility for full, and immediate, payment of any and all outstanding balances.

By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial Financial Assistance grant which may be awarded. Complete Financial Assistance policy is available on our website at HillsdaleHospital.com.

APPLICATION MUST BE COMPLETE. Incomplete applications, including lack of documentation, will cause a delay in determination. Allow 4-6 weeks for the application to be processed. If you have any questions, please contact our Financial Counselor at 517-437-5222.

_____

Responsible Party/Guarantor Signature Date

_____

Spouse Signature Date

Please forward completed applications and requested documentation to:

Hillsdale Hospital
Attn: Financial Counselor
168 South Howell Street
Hillsdale, MI. 49242