MUNSON HEALTHCARE
Paul Oliver Memorial Hospital

FORM #11541 (02/18)
SPANISH FORM #10572 (02/18)

FINANCIAL ASSISTANCE APPLICATION

PATIENT'S LEGAL NAME:		**BIRTHDATE:**	
STREET ADDRESS (NO PO BOXES):	**CITY:**	**COUNTY:**	**ZIP:**
SOCIAL SECURITY NUMBER:	**PHONE:**		
RESPONSIBLE PARTY NAME:	**RELATIONSHIP TO PATIENT:**		

Do you file taxes? ☐ **Yes** ☐ **No** **Do you have a Health Savings Account (HSA)?** ☐ **Yes** ☐ **No**
Do you have a personal checking account? ☐ **Yes** ☐ **No** **Do you have a personal savings account?** ☐ **Yes** ☐ **No**
Do you have a business checking account? ☐ **Yes** ☐ **No** **Do you have a business savings account?** ☐ **Yes** ☐ **No**
Were you a Michigan resident at the time of your hospital service? ☐ **Yes** ☐ **No**

List all persons living in your household:

NAME	AGE	RELATIONSHIP

INSURANCE QUESTIONNAIRE	**YES**	**NO**
Have you lost insurance coverage within the last 90 days?		
Was the date of service related to an auto accident?		
If yes, please provide auto claim number.		
Was the date of service related to an accident at work?		
If yes, please provide workman's compensation information.		
Are you a Veteran?		

MEDICAID QUESTIONNAIRE	**YES**	**NO**
Have you applied for Medicaid?		
Are you under 21 years of age?		
Are you pregnant?		
Are you 65 years of age or older?		
Do you have any dependents under the age of 18 living in your home?		
Are you receiving or have you applied for Social Security Disability payments?		
Are you legally blind or on dialysis?		
Have you been or do you expect to be disabled and unable to work for 12 months or more?		
Is patient age 19 – 64 with a household income at or below the following income levels?		

Household Size	Yearly Income
1 person	$16,753.20
2 person	$22,714.80
3 person	$28,676.40
4 person	$34,638.00
5 person	$40,599.60
6 person	$46,561.20
7 person	$52,522.80
8 person	$58,484.40

PLEASE PROVIDE THE FOLLOWING INFORMATION:

- ❖ Copy of your most recent Federal Tax forms with all Schedules and Attachments
- ❖ Copy of Medicaid determination letter (if applicable)
- ❖ Copy of the last 3 months' of checking and/or savings account (personal and/or business)
- ❖ Copy of the last 3 months' of proof of income

See boxes below for examples of income. Income is considered to be total income before taxes are taken out, and may include but is not limited to:

Employment wages/salaries	Unemployment	Alimony	VA benefits
Social Security (before deductions) or award letter	Lump sum payments	Gov't assistance	Annuities
Pension or retirement	Self-employment records	Odd jobs	Any other income
Worker's compensation award letter	Cash receipts	401 K distributions	

TYPE OF INCOME	PATIENT	SPOUSE OR OTHER HOUSEHOLD MEMBER	INCOME AMOUNT
1.			
2.			
3.			
4.			

Proof of No Income

*****This question MUST be completed if you are claiming no income*****

Briefly explain how you are being supported and amount of monthly support. _____

_____

_____

Medical Bills: Please list any other medical bills you may have: _____

_____

_____

Please call the phone number listed on each bill and inform the provider that you are applying for Munson's Financial Assistance Program. The provider may match Munson Healthcare's Financial Assistance determination.

***CERTIFICATION**: By signing this document, I affirm the answers on this application are true, should a subsequent review of an individual's financial assistance application reveal that information provided by the individual was either incorrect or fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed. I understand that the information which I submit is subject to verification by my hospital provider, including credit reporting agencies, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release to my hospital provider my proof of income.*

PATIENT SIGNATURE: _____

APPLICANT OR REPRESENTATIVE SIGNATURE:_____

RELATIONSHIP (IF NOT PATIENT): _____

DATE: _____

MAIL COMPLETED APPLICATION AND DOCUMENTATION TO:

Paul Oliver Memorial Hospital
c/o Munson Medical Center, 1105 Sixth St, Traverse City, MI 49684
Attention: Patient Financial Services
For assistance, call 231- 935-7062 or 800-437-3615