

(For Hospital Use Only)
Application Origin: _____

Account #s: _____



West Michigan Financial Shared Services Center
CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

Application Date: _____

(For Hospital Use Only)

Pending
Approved
Denied

Patient Name _____ Date of Birth _____

Address _____ Telephone _____ Msg Ph _____

City/State/Zip _____ Social Security Number _____

Mailing Address (if different) _____ City/State/Zip _____

EQUITY IN CARE (Optional)

Race: _____ Ethnicity: _____

Preferred Language: English Spanish Other: _____

Do you have an outstanding balance with the hospital? If yes, amount due: \$ _____

Hospital name: _____

PLEASE PROVIDE THE FOLLOWING FOR ALL HOUSEHOLD MEMBERS (ATTACH ADDITIONAL SHEET IF NECESSARY)

Name	Date of Birth	Relationship to Patient	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have insurance? No If yes, Insurance Name: _____

Insurance Plan/ID: _____

Do you have Medicaid? No If yes, Medicaid ID: _____

Do you have Medicare? No If yes, Medicare ID: _____

Do you receive assistance with medical bills? No If yes, Member IDs: _____

(For example: Access Health, Amish, Calhoun Health Dept., Church, Kent Health Dept., Indian Reservation, Muskegon Care, Sliding-fee Scale, or Tencon)

Have you applied for Disability? No If yes, when: _____

Is anyone in the household a veteran? No If yes, name: _____

CONTINUES ON NEXT PAGE

EMPLOYMENT

Person(s) employed in household _____ Employer _____ Amount before taxes _____ Per (circle one)
 _____ Wk 2wks Mo
 _____ Wk 2wks Mo

Is there a member of the household who became unemployed within the past 90 days? No If yes, Name: _____

Were health benefits received by this person? No Yes

MONTHLY HOUSEHOLD INCOME FROM OTHER SOURCES

MONTHLY **ANNUALLY**
(for Office Use Only)

Child Support/Alimony \$ _____
 Federal Assistance Program... Type _____ (for example, Cash/Food Stamps).. \$ _____
 Pension / IRA / 403(b) / Annuity Cashout..... \$ _____
 Social Security/Social Security Disability..... \$ _____
 Unemployment or Workers Comp ... (start date: _____/end date: _____)..... \$ _____
 Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)..... \$ _____
TOTAL MONTHLY GROSS INCOME... including income from employment..... \$ _____

ASSETS

Cash on hand..... \$ _____
 Checking Account Balance..... Bank _____ \$ _____
 Savings Account Balance..... Bank _____ \$ _____
 Retirement Savings Account..... Bank _____ \$ _____
 Investments or Other Securities..... \$ _____
 Life Insurance Policy Cash Value..... \$ _____
 Real Estate other than Primary Residence Location: _____
 Value: \$ _____

List below vehicles owned: (include cars, trucks, snowmobiles, RVs, motorcycles, etc.)

Type of Vehicle	Year	Value
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

TOTAL ASSETS..... \$ _____

CONTINUES ON NEXT PAGE

MONTHLY HOUSEHOLD LIABILITIES/EXPENSES

MONTHLY

**PAST DUE
BALANCE**

ANNUALLY
(for Office Use Only)

Rent/Mortgage.....(Mortgage Balance \$ _____)	\$ _____		
Grocery Expenses.....	\$ _____		
Child care.....	\$ _____		
Child support/Alimony.....	\$ _____		
Utilities.....Gas \$ _____ Electric \$ _____ Water/Sewer \$ _____	\$ _____		
Telephone.....Mobile/Cell \$ _____ Home \$ _____	\$ _____		
Medication Expenses (co-pays, cash pay, etc.).....	\$ _____		
Medical Expenses (doctor visits, hospital expenses, other providers).....	\$ _____		
Insurance Premiums...Life \$ _____ Auto \$ _____ Home \$ _____	\$ _____		
Car Loan Payments.....Balance owed \$ _____	\$ _____		
Transportation (Bus, taxi).....	\$ _____		
Loan Payment.....Type _____ Balance \$ _____	\$ _____		
Credit card payment.....(Total credit card balance(s) owed \$ _____)	\$ _____		
TOTAL EXPENSES.....	\$ _____		

- Are you under age 21..... Yes No
- Are you age 65 or older?..... Yes No
- Are you pregnant now or have you been within the last 3 months?..... Yes No
- Are you blind or disabled?..... Yes No
- Are you a parent or close relative living with and acting as a parent for a child under the age of 18?..... Yes No

A) If you answered "Yes" to any of the above questions, you will need to include a Medicaid Determination Letter with this application. If you do not have one, you will need to apply for one.

B) If you have no income, you must complete a letter of support to be signed by the person(s) contributing to your housing.

VERIFICATION OF INCOME AND IDENTIFICATION

I hereby authorize Trinity Health (Mercy Health Partners, Saint Mary's Health Care, Battle Creek Health System, Saint Joseph Regional Medical Center and Muskegon Community Health Project and affiliate provider offices) to release information on file to assist in the enrollment of various health and human service programs for which I apply. I understand this information may include financial information, medical information and/or any other information contained in my file.

The U.S. Department of Health and Human Services (HHS) enforces the federal privacy regulations commonly known as the HIPAA Privacy Rule (HIPAA). HIPAA requires most doctors, nurses, pharmacies, hospital, nursing homes and other health care providers to protect the privacy of your health information. Even though HIPAA requires health care providers to protect your privacy, providers are permitted, in most circumstances to communicate with the patient's family, friends, or others involved in their care or payment for care.

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I also understand that I will be liable for repayment of any services rendered at Trinity Health affiliates if the above information is given under false pretenses.

SIGNATURE _____

DATE _____

SPOUSE'S SIGNATURE _____

DATE _____

(if applicable)

Attachment 1

For use at Mercy Health Partners in Muskegon only

If applying for medication coverage or vision assistance, please complete this page, as this assistance is coordinated through the Muskegon Community Health Project.

PROVIDER & MEDICATION ASSISTANCE

Primary Physician _____

Office _____ Phone Number _____

Address _____ City/State/Zip _____

Do you have an outstanding balance with your physician? If yes, amount due: _____

Account Number(s): _____ Account Number(s): _____

Are you pregnant (circle one): Yes No

CURRENT MEDICATIONS

Name and dose	Times per day	If prescribed by a different physician, list name of physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have Medicare Part D? No If yes, Plan/ID: _____

Do you have any Prescription Coverage? No If yes, Plan/ID: _____

VISION ASSISTANCE

Have you received help from the Lion's Club before? Yes No

If yes, when and what type: _____

When was the last time you had your vision tested? Date: _____ Where: _____

Applications rendered _____ Date _____

1171 Program _____ PAP Diabetes FA Other _____

Staff initials _____ Comments _____