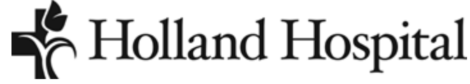


FINANCIAL ASSISTANCE APPLICATION

DATE OF APPLICATION: ________________

Responsible Party Information	**Spouse/Partner Information**
Responsible Party Name________________________	Spouse/Partner Name________________________
Date of Birth ________________________	Date of Birth ________________________
Relationship to Patient ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other ________________________	Relationship to Patient ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other ________________________
Marital Status ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated	Marital Status ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated
U.S. Citizen ☐ YES ☐ NO	U.S. Citizen ☐ YES ☐ NO
Address ________________________ ________________________	Address ________________________ ________________________
Phone Number (____) ____ - ________	Phone Number (____) ____ - ________
Place of employment. ________________________ (If unemployed, please provide a letter of support)	Place of employment. ________________________ (If unemployed, please provide a letter of support)

Dependents (under age 18)

Dependents Name	Date of Birth

Have you applied for Medicaid? ☐ YES ☐ NO

Please submit the following required documents with application:

- Last two months bank statements
- Last 30 days of paystubs with year to date totals
- Most recent tax return if self-employed, rental or farm income
- If no income, letter of support
- Medicaid denial letter

INCOME VERIFICATION (Based on Gross Monthly Income)			
Monthly Income Sources	**Responsible Party**	**Spouse/Partner**	**Combined Monthly Income**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
State Assistance (ie: food stamps)	$	$	$
Other(s)	$	$	$
ASSETS**Must list all available funds**			
Assets	**Name on Account**	**Bank Name**	**Current Balance**
Checking account(s)			$
Savings account(s)			$
Money Market			$
Health Savings			$
Flexible Spending			$
Retirement Account(s) (ie 401K/IRA)			$
Other(s)			$
			$

ADDITIONAL ASSETS (Automobiles, motorcycles, house (s), property, any other)		
Assets:	Estimated value:	Balance due: (if applicable)

SIGNATURE

I certify that all information is valid and complete and herby authorize Holland Hospital to request a credit check report and/or verify any of the above information as deemed necessary.

_______________________________ __________

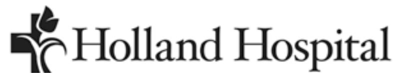
Responsible Party Signature Date

_______________________________ __________

Spouse/Partner Signature Date

Return completed application with all verification to:

Holland Hospital
Patient Financial Services
602 Michigan Avenue
Holland, MI 49423-4918
616-394-3626



602 Michigan Avenue + Holland, Michigan 49423-4999 + main: 616.392.5141 + hollandhospital.org

The following is a check list of verifications required to be returned with your application.
If you are married, be sure to include verifications for your spouse. If you are separated, please provide legal document for proof. Some items may need additional explanation or may not apply, in these cases please explain or circle "N/A". Otherwise, if you circle "Yes" please make sure your documents are included for review.

Copy of most recent tax return if self-employed, rental or farm income	Yes	No	N/A
Recent copies of pay-stubs with year to date earnings, (30 days)	Yes	No	N/A
Proof of other income	Yes	No	N/A
Letter of support if unemployed	Yes	No	N/A
Current bank statements with all pages (2 months)	Yes	No	N/A
Current statement for your IRA, 401K, HSA, FSA, MM	Yes	No	N/A
Have you applied for Medicaid? (If no, please explain)	Yes	No	N/A
Have you applied for Marketplace medical coverage? (If no, please explain)	Yes	No	N/A

Explanation: ____

____

Please return the completed application and supporting documents to:
Holland Hospital
Patient Financial Services
602 Michigan Ave.
Holland, MI 49423

Please complete the front and back of the application. Failure to return a **completed, signed and dated** application with all supporting documentation may result in a denial of your application. **Please do not send originals**.

Thank You,

Holland Hospital
Patient Financial Services