

### CONFIDENTIAL FINANCIAL ASSISTANCE APPLICATION

Please fill out all information requested. If it does not apply, indicate that by writing or circling "NA," as appropriate to the section of the form. Attach additional pages if needed. **Incomplete or false information on the application may result in a denial of the application, and the account balance due will be your responsibility.** Please refer to Holland Hospital's Financial Assistance Policy for more information before completing the application. If you have any questions or need help with completing this application, please call 616-394-3626 or email <u>billing@hollandhospital.org</u>

#### PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may validate all the information and may ask for additional information.
- Within 14 calendar days after we receive your completed application and documentation, we will mail you a determination letter.

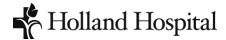
RESPONSIBLE PARTY INFORMATION								
Responsible Party First Name		Middle Name		Last Name				
□ Male □ Female		Birth Date (MM/DD/YY	YY)	Social Security # (optional – but requested for more				
				complete review and faster response)				
Other (may specify)		Leat Name	Dinth Data					
Spouse First Name	Middle Name	Last Name	Birth Date	Social Security # (optional – but requested for more complete review and faster response)				
Mailing address of person res	ponsible for payi	ng bills		Main contact phone number(s):				
				( )				
				( )				
				Email address:				
City		State	Zip Code					
Employment status of person								
				g unemployed):				
Self-employed	Self-employed  Student  Disabled  Retired  Other							
		FAMILY INFO	RMATION					
List family dependents in your household under the age of 18.								
FAMILY SIZE: _	Attach additional page if needed							
FUL	L NAME		DATE OF BIRTH	RELATIONSHIP TO APPLICANT				

Have you applied for Medicaid? □ Yes □ No (you may be required to be screened for Medicaid eligibility)



INCOME VERIFICATION (Based on Gross Monthly Income)							
Monthly Income Sources	Responsibl	e Party	Spouse				
Employment Income (wages)	\$		\$				
Social Security	\$		\$				
Disability	\$		\$				
Unemployment	\$		\$				
Spousal/Child Support	\$		\$				
Rental Property	\$		\$				
Investment Income	\$		\$				
State Assistance (i.e., food stamps)	\$		\$				
Pension/Dividends	\$		\$				
Tips/Commission	\$		\$				
Workers' Compensation	\$		\$				
Other(s)	\$		\$				
· ·	ASSETS **Must list	all available fund					
Assets	Name on Account	Bank Nar					
Checking account(s)			\$				
Savings account(s)			\$				
Money Market account(s)			\$				
Health Savings account(s)			\$				
Flexible Spending account(s)			\$				
Retirement account(s) (i.e.,			\$				
401K/IRA)			Ť				
Stocks/Investment accounts			\$				
Other(s)			\$				
List additional Che	cking or Savings Account	s below. Attach a	dditional pages if needed.				
			\$				
			\$				
			\$				
ADDITIONA	L ASSETS (Automobiles, ı	motorcycles, hous	e(s), property, etc.)				
Asset	Estimate	d Value	Balance Due (if applicable)				
Signature required to process application: I certify that all information provided on this application and the supporting documentation are true and complete to the best of my knowledge. I will apply, as required, for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I hereby authorize Holland Hospital to request a credit check report and/or verify any of the above information, as deemed necessary. I understand that if I knowingly provide inadequate or incomplete information in this application, I may be ineligible for financial assistance, and any financial assistance granted to me may be reversed and I will be responsible for the payment of my medical bills.							
Responsible Party Signature:	Date:						

Spouse Signature:



## FINANCIAL APPLICATION CHECKLIST

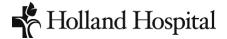
Please refer to Holland Hospital's Financial Assistance Policy before completing the application. If you have any questions or need help with completing this application, please call 616-394-3626 or email <u>billing@hollandhospital.org.</u> The following is a *checklist of documentation required to be returned with your application. If you are married, you are required to provide documentation for both you and your spouse.* If you indicate "Yes" to any of the documents below, please make sure that the documents are included with the application for review.

Please complete both pages of the application. Failure to return a completed, signed and dated application with all supporting documentation may result in a denial of your application, and any account balance due will be your responsibility.

1.	Proof of permanent residency in Michigan	Yes	No	N/A
2.	If you are self-employed and/or have rentals or farm income, attach a copy of your most recent Federal Tax forms with all Schedules and Attachments	Yes	No	N/A
3.	Recent copy of pay stubs with year-to-date earnings from the past 30 days	Yes	No	N/A
4.	Proof of any other income (such as Social Security, Disability, spousal support, child support, etc.)	Yes	No	N/A
5.	Letter of support if unemployed ( <i>letter explains who is financially supporting you if you are not employed. Letter needs to be dated and signed by supporting individual – i.e., parent, significant other, etc.</i> ) See attached form	Yes	No	N/A
6.	Bank statements for <u>ALL</u> checking and savings accounts with your and/or your spouse's name on them. Statements must be from the bank and include all pages, even if blank	Yes	No	N/A
7.	Current statement for your IRA, 401K, HAS, FSA, MM	Yes	No	N/A
8.	Have you applied for Medicaid? If <b>Yes</b> , please provide approval or denial letter. If <b>No</b> , you may need to utilize our Medicaid Enrollment Partner, Med screened and/or to apply for Medicaid. You may reach MedAssist at		•	N/A

#### Please return completed application and supporting documents by one of the methods below:

Mail:	Fax:	Email:
Holland Hospital	Attention Advocate Office	Billing@hollandhospital.org
Attn: Patient Advocates	616-494-4079	Attention Advocate Office
602 Michigan Avenue		
Holland, MI 49423-4918		



# **Financial Support Statement**

If you report monthly income of \$0.00, please have the Support Statement filled out by the person(s) helping you and/or your family. In all other cases, please skip this section.

	(	To be com			SUPPORT ST		<b>MENT</b> pport to the	applicar	it)		
Print Full Name: Phone #: ( )					)						
Address:											
City					State			Zip Code			
Relationship	to Patient: _						Dat	e of Birth	1:		
I have been in the applicant		the applica	ant as pro	oviding fir	nancial supp	port.	Below is a l	ist of ser	vices or	support l	provide
I hereby certi belief. I unde											
Signature (re	quired)										
Date											