

Confidential Financial Assistance Application

Please fill out all information requested. If it does not apply, write, "NA." Attach additional pages if needed. Incomplete or false information on the application will result in a denial of the application and the account balance due will be your responsibility. If you have any questions or need help with completing this application, please call (616) 394-3626 or email billing@hollandhospital.org

Please Note

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check 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	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify)		Birth Date (MM/DD/YYYY)		Social Security # (optional – but requested for more complete review and faster response)	
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 responsible for paying bills				Main contact phone number(s):	
_____				()	
_____				()	
_____				Email address:	
City		State	Zip Code		
Employment status of person responsible for paying bill					
<input type="checkbox"/> Employed (date of hire): _____ <input type="checkbox"/> Unemployed (how long unemployed): _____ <input type="checkbox"/> Self-employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other _____					

Family Information

List family dependents in your household under the age of 18.

Family Size: _____ *Attach additional page if needed*

Full 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	Responsible 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	\$	\$
Worker's Compensation	\$	\$
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) (i.e. 401K/IRA)			\$
Stocks/Investment accounts			\$
Other(s)			\$

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

Signature required to process application: I certify that all information is valid and complete and I hereby 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 Signature: _____ Date: _____

Financial Application Checklist

The following is a checklist of documentation required to be returned with your application. If you are married, please provide documentation for both you and your spouse. If you indicate "Yes" to any of the documents below, please make sure that your 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.

If you are self-employed, have rentals or farm income, attach copy of most recent Federal Tax forms with all Schedules and Attachments	Yes	No	N/A
Recent copy of pay-stubs with year-to-date earnings from the past 30 days	Yes	No	N/A
Proof of any other income (<i>such as social security, disability, spousal support, child support, etc.</i>)	Yes	No	N/A
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
Formal bank statements with all pages for the past 2 months (<i>must include the institution's logo and account holder's full name and address</i>)	Yes	No	N/A
Current statement for your IRA, 401K, HAS, FSA, MM	Yes	No	N/A
Have you applied for Medicaid? <i>If Yes, please provide approval or denial letter.</i> <i>If No, you may need to utilize our Medicaid Enrollment Partner – MedAssist to be pre-screened and/or to apply for Medicaid. You may reach out to MedAssist by calling (616) 394-3795</i>	Yes	No	N/A

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

Mail:
Holland Hospital
Patient Financial Services
Attn: Patient Advocates
602 Michigan Avenue
Holland, MI 49423-4918

Fax:
Attention Advocate Office
616-494-4079

Email:
Billing@hollandhospital.org
Attention Advocate Office

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.

Financial Support Statement

(To be completed by the person providing support to the applicant)

Print Full Name: _____ Phone: () _____

Address: _____

City

State

Zip Code

Relationship to Patient: _____ Date of Birth: _____

I have been identified by the applicant as providing financial support. Below is a list of services or support I provide the applicant.

I hereby certify and verify that all of the above information is true and correct to the best of my knowledge and belief. I understand that my signature will not make me financially responsible for the patient's medical charges.

Signature (required)

Date