Holland Hospital

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 before completing the application. 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 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 □ 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 _____ _____ _____ City State Zip Code				Main contact phone number(s): ( ) ( ) Email address:

Employment status of person responsible for paying bill

□ **Employed** (date of hire): _____ □ **Unemployed** (how long unemployed): _____

□ **Self-employed** □ **Student** □ **Disabled** □ **Retired** □ **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)

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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	$	$
Workers' 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 account(s)			$
Health Savings account(s)			$
Flexible Spending account(s)			$
Retirement account(s) (i.e., 401K/IRA)			$
Stocks/Investment accounts			$
Other(s)			$
List additional Checking or Savings Accounts below. Attach additional pages if needed.			
			$
			$
			$

ADDITIONAL ASSETS (Automobiles, motorcycles, house(s), property, etc.)		
Asset	**Estimated 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: _____ Date: _____

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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 billing@hollandhospital.org. 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 within our service area	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 (*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.)* See attached form	Yes	No	N/A
6. The most recent two (2) months of bank statements for **ALL** 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 **Yes**, please provide approval or denial letter.* *If **No**, you may need to utilize our Medicaid Enrollment Partner, MedAssist, to be pre-screened and/or to apply for Medicaid. You can reach MedAssist at 616-394-3795.*	Yes	No	N/A
9. College/university students under the age of 24 are required to apply for Medicaid.			
10. College/university students: if you are claimed by your parent(s) on their taxes, please provide all required information above for your parent(s)/guardian(s).			

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

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

Fax:
Attention Advocate Office
616-494-4079

Email:
Billing@hollandhospital.org
Attention Advocate Office

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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 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