METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Financial Assistance Application

FINANCIAL ASSISTANCE PROGRAM

As part of our mission, Metro Health is committed to providing access to quality health care to our community, and to treating all our patients with dignity, compassion and respect.

Our Financial Assistance Program provides services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for part or all of their care. Our Financial Assistance Program provides discounts up to 100 percent of hospital/physician charges to patients who meet financial eligibility guidelines.

When applying for Financial Assistance, your cooperation is needed in providing the information and supporting documentation necessary for us to make a fair and timely decision. If complete and accurate information is not provided, your application may be rejected or denied without further review, in which case you will be expected to pay your bill in full.

Given the sensitive nature of these requests, all communication with the patient or family members will be handled in strict confidence and in a compassionate manner.

Thank you for selecting Metro Health for your health care needs. We take pride in serving the health care needs of our community!

Copies of this application form are available in English, Spanish, Arabic, Bosnian, Burmese, Chinese-Mandarin, Nepali, Kinyarwanda, Korean, Somali, Swahili and Vietnamese

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This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for our Financial Assistance Program.

COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Financial Assistance Program. In that case, you will be responsible for the full balance due on your account.

If you need help in completing this form or gathering the supporting materials, please contact a Metro Health Customer Service Representative at 616-252-7110 or 1-800-968-0051.

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (state driver's license/state ID).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last two months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, etc.
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter.
- ✓ Copies of bank statements for checking, savings, certificates of deposit, etc. for the last two months.
- ✓ A copy of a current utility bill, telephone bill, or cable television bill from the residence at which you reside.
- ✓ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.
- ✓ If you report $0 income on the following page, a completed Support Statement (at the end of the form) from any person(s) providing support to you or your family.

☞ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided.

Please contact a Metro Health Customer Service Representative at the above number to schedule an on-site or telephone interview.

The Patient Protection and Affordable Care Act requires all individuals to have health insurance coverage effective as of January 1, 2014. Our Metro Representatives will provide you with information as to how you can apply for health insurance coverage through the federal insurance exchange at "www.marketplace.gov" and can help you with the enrollment process.

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APPLICATION FOR FINANCIAL ASSISTANCE

PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION

Patient Name:_____ Patient Date of Birth: _____

Patient's Social Security #:_____

Spouse's Name:_____ Spouse's Date of Birth: _____

Spouse's Social Security #: _____

Telephone: _____ Patient Account Number:_____

Street Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Household Members (Legal tax dependents) Married _____ Single _____ Divorced _____ Widow(er) _____

Name: _____ Relationship: _____ Social Security # _____ Age: _____

Name: _____ Relationship: _____ Social Security # _____ Age: _____

Name: _____ Relationship: _____ Social Security # _____ Age: _____

Name: _____ Relationship: _____ Social Security # _____ Age: _____

Name: _____ Relationship: _____ Social Security # _____ Age: _____

Name: _____ Relationship: _____ Social Security # _____ Age: _____

If there is no income, who is supporting you? _____

Relationship: _____ Telephone Number: (____)_____

Applicable expenses:

Medical Insurance Premiums: $	Medical Bills/Expenses: $

Financial Assistance Application (Continued)

Does any family member receive any income from employment or self-employment? If self-employed, include profit & loss statement or a copy of last year's tax return. [ ] Yes [ ] No If yes, complete the following	Total Monthly Earnings Before Deductions
Person Working	$
Person Working	$

Other income you have. Include income of all family members. Every item must be completed.

TYPE OF INCOME	Check Yes/No	MONTHLY AMOUNT	WHOSE INCOME
Social Security Benefits (RSDI)	[ ] Yes [ ] No	$	
Supplemental Security Income (SSI)	[ ] Yes [ ] No	$	
Retirement or Pension Benefits	[ ] Yes [ ] No	$	
Veterans Benefits	[ ] Yes [ ] No	$	
Disability Benefits	[ ] Yes [ ] No	$	
Rental Income	[ ] Yes [ ] No	$	
Worker's Compensation	[ ] Yes [ ] No	$	
Child Support or Alimony	[ ] Yes [ ] No	$	
Unemployment Compensation	[ ] Yes [ ] No	$	
Military Allotments	[ ] Yes [ ] No	$	
Casino profit sharing/Distribution	[ ] Yes [ ] No	$	
Other	[ ] Yes [ ] No	$	

Assets you have: Include assets of all family members. Every item must be completed. **Attach all supporting documentation.**

TYPE OF ASSET	Check Yes/No	VALUE OF ASSET
Cash on hand, in a safety deposit box or patient trust fund	[ ] Yes [ ] No	$
Savings, Checking, or Credit Union Accounts	[ ] Yes [ ] No	$
Home, Life Estate, Life Lease	[ ] Yes [ ] No	$
Real Estate (other than your home)	[ ] Yes [ ] No	$
Mortgage, land contract or other notes payable to household member	[ ] Yes [ ] No	$
Savings bonds or money market funds	[ ] Yes [ ] No	$
Stock or mutual funds	[ ] Yes [ ] No	$
**IRA, KEOGH, 401K, 403b or deferred compensation accounts	[ ] Yes [ ] No	$
**IRA/401K/403b Penalty for early withdrawal information		
Date began contributing/ participating in IRA, 401K, 403b, KEOGH, or deferred compensation accounts	Date:	
Life Insurance (whole life)		$
Annuity	[ ] Yes [ ] No	$
Cars,Trucks,Boats, Motorcycles, Other vehicles (list each separately) Please provide make, model, year, and mileage for each.	[ ] Yes [ ] No [ ] Yes [ ] No [ ] Yes [ ] No [ ] Yes [ ] No	$ _____ $ _____ $ _____ $ _____
Certificates of Deposit (C.D.) or savings certificates	[ ] Yes [ ] No	$
Trust Fund	[ ] Yes [ ] No	$
Have you paid for medical expenses exceeding 7.5% of your adjusted gross income this year?	[ ] Yes [ ] No	
Burial Plots	[ ] Yes [ ] No	

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CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Metro Health Hospital, and I authorize Metro Health Hospital to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature_____ Date of Request_____

Your completed application and supporting documentation may be submitted by:

- Hand-delivering the materials to:
  - A Metro Health Representative
  - Financial Counselor or Cashier at Metro Health Hospital Lobby or any Patient Registration/Check in Desk.
- Mailing the materials to Metro Health Hospital, Attn: Customer Service, PO Box 913 Wyoming, MI 49509-0913
- E-mailing the materials to CustomerService@metrogr.org.

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SUPPORT STATEMENT

If you report monthly income of $0, please have the Support Statement filled out by the person(s) helping you and/or your family. In all other cases, skip this section.

Support Statement

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

Print Full Name: _____ Phone # (_____) _____

Address: _____
Street City State Zip Code

Social Security Number: _____ 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: _____

*** Please attach proof of residency, such as a copy of a utility bill, with your current address on it, dated within 60 days from the date of the hospital service.