Financial Assistance Application

1. Applicant information.

Last Name First Name Mi	Charity Care Sequential Control Number
Street Address	Telephone Numbers Home Work Cell
City State Zip Code	Mailing Address (if different from Street Address)
Date of Birth	__ Male __ Female - Are you pregnant? __ Yes __ No

Are you: homeless? __Yes__No
Unemployed? __Yes__No
Uninsured? __ Yes__No

2. If you are applying for someone else, complete this section.

Last Name First Name Mi	Relationship to Applicant:
Street Address	Telephone Numbers Home Work Cell
City State Zip Code	Mailing Address (if different from Street Address)

3. Family Information. List the people in your family that live with you and you support with your income. Include your spouse, dependent children under age 18, and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parents or parents who live with you.

Name of Family Member	Relationship	Date of Birth	Gender	Pregnant
			M F	Y___ N___
			M F	Y___ N___
			M F	Y___ N___
			M F	Y___ N___

4. List Earned Income before taxes and deductions for each family member who works.

Name of Working Family Member	Employer Name & Address	Amount Earned	How Often? Weekly/Monthly/Annually

5. Other Income not from an Employer.

Type of Income	Family Member Receiving Income	Amount	How Often? Weekly/Monthly/Annually
Social Security			
Railroad Retirement			
Veteran's Benefits			
Retirement Funds			
Annuities			
Pensions			
Child Support			
Alimony			
Unemployment			
Workers Compensation			
Rental Income			
Trust Income			
County General Relief			
Refugee Resettlement Program			
Dividend Income			
Bank Account Income			
Other Income, Please specify			

6. Other Expenses. Fill in this section if you or anyone in Section 3 are required to make payments for any of the below expenses along with proof of those expenses.

Payment Type	Recipient Name/Relationship	Amount Paid	How Often? Weekly/Monthly/Annually
Alimony			
Child Support			
Car Payment			
Mortgage/Rent			
Utilities			
Credit Cards			
Other			

7. Other Insurance. Charity Care can pay for such things as your co-payments and deductibles even if you have other health insurance.

a. Are you covered under any other health insurance program, including Medicare? Y____N____if yes:

Policy Holder (Name)	Insurance Company	Policy Number

b. Are you seeking Charity Care because of a work-related accident or injury? Y____N ____

c. Are you seeking Charity Care because of a car accident? Y____N ____

d. Are you a student? Y____N _ If yes, are you full time?____Part time? ____

e. Do you have an application pending for any of these programs? (Check all that apply)

Medicaid____ Medicare ____

f. Are you currently approved for Charity at another hospital or community health center? Y______N______

g. If yes, where? ____

8. Medical Bills. Total medical bills ____

Why can't you pay your medical expenses? Why do you need Charity Care?

____
____
____
____
____
____

9. Ethnicity/Race. Ethnicity/Race will not be used to determine eligibility.

___ Asian or Pacific Islander

___ African American, not Latin

___ Latino

___ American Indian or Alaskan Native

___ Caucasian, not Latino

___ Other_______________________

___ I do not wish to answer

This is for data collection and analysis purposes only.

10. Assignment of Rights. Read this section carefully and sign.

I agree to tell this hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Financial Assistance.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

I understand that this hospital cannot share confidential information with any state or federal agency without my prior approval.

________________________________ ________________

Signature of Applicant Date

________________________________ ________________

Signature of authorized representative Date

If you have questions about this application, contact the Financial Assistance Representative at 269-273-9769.

Mail the completed application to: Three Rivers Health 701 S. Health Parkway Three Rivers, MI 49093

Appendix A (translated) Financial Assistance Application