Harbor Beach Community Hospital

FINANCIAL ASSISTANCE APPLICATION

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels.

Incomplete forms will not be processed. Income verification must be submitted for this form to be considered complete.

Patient Name:	Spouse:
DOB:	DOB:
Street: City: State: Zip:	Street: City: State: Zip:
Phone:	Cell Phone:
Employer:	Employer:
Employer Phone Number:	Employer Phone Number:

List all Medical/Hospitalization/Health Insurance you currently have or are eligible for:	
Type of Insurance	Plan Number

Please list spouse and dependents. Number of related persons living in your household:_____

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income				
Source	**Self**	**Spouse**	**Other**	**Total**
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment				
Unemployment, worker compensation, strike benefits				
Rent, interest, dividend, and other income				
Total income				

Please attach copies of the following for both spouses:

- Drivers License
- Insurance Cards
- Birth Certificate or Social Security Card for all dependents
- Most recent check stub from all employers
- Prior Year Tax Return

Client Affirmation:
Harbor Beach Community Hospital has my permission to verify all information contained in my Financial Assistance Application, including the Additional Information Required.

I affirm that the information I have reported is true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance.

Patient Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

This form is for hospital related charges from Harbor Beach Community Hospital, Harbor Beach, Michigan. It does not apply toward doctor or other provider charges. If you receive medical bills from other providers, you will need to contact them directly to arrange payment options.

FOR HARBOR BEACH COMMUNITY HOSPITAL USE ONLY:

Verification Checklist (attach copies)	**Yes**	**No**
Identification: Please attach: Driver's license (for both spouses)		
Birth certificate or Social Security Card for all dependents and both spouses.		
Income: Prior year tax return and most recent pay stubs, or other (if applicable)		
Insurance: Insurance card(s)		

Total Income from Last Years Tax Return:	

Income from Last Check Stubs:		**Dollar Amount**
List Employers		
	Total	
Income from other sources		
	Total	
	Total = Employer and Other	
	Annualize	

Financial Assistance: _____ Approved _____ Denied

Patient Pay _____ % Effective Date _____

Recertification Date:_____

Approved By:_____
Director of Business Office Date

If discount over $2,000 or special circumstance, approved by:

_____ _____
Vice President Fiscal Services Date President Date

COMPLETE INFORMATION OF BOTH SIDES OF THIS FORM