

Metro Health Hospital
P.O. Box 159
Grand Rapids, MI 49501

APPLICATION FOR FINANCIAL ASSISTANCE

PERSONAL INFORMATION:

Patient Name: _____ Phone # _____

Spouse/Parent: _____ Social Security # _____

Street Address: _____ City, St. _____ Zip _____

Patient Date of Birth _____ Medicaid ID# _____ or Date of App _____

Patient Employer: _____ Spouse Employer: _____

Patient is _____ not working, _____ working part time, _____ working full time

Date of last employment _____

Spouse/Parent is _____ not working, _____ working part time, _____ working full time

Date of last employment _____

Account # _____ or Proposed Procedure _____

Contact Dr. _____ Phone # _____

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 _____

PROOF OF TOTAL GROSS INCOME: (Documentation is required for current year)

IF YOU HAVE NO INCOME, PLEASE SIGN THE DECLARATION OF INDIGENCY STATEMENT.
IF YOU DID NOT RECEIVE ONE WITH THIS APPLICATION, PLEASE CALL 616-252-7110 OR
1-800-968-0051 TO REQUEST ONE.

____ Copy of Check Stubs _____ Copy of Unemployment Check Stubs
____ Copy of Disability Check Stubs _____ Copy of Social Security Deposit
____ Food Stamps _____ Pension/Dividend Check Deposits
____ FIA Assistance _____ Alimony/Child Support
____ Commission/Tips _____ Other

