

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

