

METRO HEALTH HOSPITAL

P.O. Box 159
Grand Rapids, MI 49501

APPLICATION FOR FINANCIAL ASSISTANCE

PERSONAL INFORMATION:

Patient Name: _____ Phone # _____

Street Address: _____ City, St. _____ Zip _____

Social Security # _____ Medicaid ID # _____ or Date of app _____

Guarantor Name _____ Phone # _____

Street Address: _____ City, St. _____ Zip _____

Social Security # _____ Relationship to patient _____

Employer: _____ Phone # _____ How long? _____

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 _____

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

Date of last employment _____

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

Date of last employment _____

PROOF OF TOTAL GROSS HOUSEHOLD INCOME: (DOCUMENTATION IS REQUIRED FOR CURRENT YEAR INCOME)

IF YOU HAVE NO INCOME, PLEASE SIGN THE DECLARATION OF INDIGENCY STATEMENT. IF YOU DID NOT RECEIVE THIS FORM YOU CAN CALL 616-252-7110 OR 1-800-968-0051 TO REQUEST ONE OR THIS FORM IS AVAILABLE ON OUR WEBSITE, WWW.METROHEALTH.NET.

_____ Copy of Check Stubs _____ Copy of unemployment check stubs

_____ Copy of Disability Check Stubs _____ Copy of Social Security Deposit

_____ Pension/Dividend check deposits _____ Food Stamps

_____ FIA assistance _____ Alimony/Child Support

_____ Commission/Tips _____ Other

Assets Documentation:
(Copy of Bank/Investment Statements)

	Name of Bank or Credit Union	Value
Cash/Checking Acct	_____	\$ _____
Savings	_____	\$ _____
Investments	_____	\$ _____
Whole Life Ins	_____	\$ _____
Home (Assessed Value)	_____	\$ _____
CD's	_____	\$ _____

Vehicles	Year/Make	Payment/Mo	Bal due
Auto Truck Van	_____	_____	_____
Auto Truck Van	_____	_____	_____
RV ATV SUV	_____	_____	_____
Boat/Snowmobile	_____	_____	_____
Trailers	_____	_____	_____

Expense Documentation:
(Copies of current monthly expense)

_____ Mortgage	_____ Child Support	_____ Cable TV
_____ Rent (Copy of lease)	_____ Utilities	_____ Water/Sewer
_____ Child Care	_____ Medical Expenses	_____ Trash Removal
_____ Medical Ins pmts	_____ Clothing Exp	_____ Life Ins. Pmts
_____ Groceries	_____ Bus/Taxi Fare	_____ Other
_____ Credit Card pmts	_____ Bank Loans	

I certify that the information I have provided is true and accurate to the best of my knowledge. I will apply for any and all assistance that may be available through federal, state, local government and private sources to help pay this hospital bill. I hereby grant permission and authorize MDHS (Michigan Department of Human Services) to release the following information to Metro Health Hospital. The amount of monthly food and/or cash assistance provided to my household by MDHS, and/or the status of my Medicaid application. If the application is not approved, the reason for disapproval. The purpose of this requested information is to determine eligibility for financial assistance for Metro Health Hospital bill(s). I understand that the information that is obtained for verification, including credit agency scoring is subject to review by federal and/or state agencies and others as required.

Signature of Applicant

Date

Please send completed application and documentation to: **Metro Health Hospital**
P.O. Box 159
Grand Rapids, MI 49501