DECLARATION STATEMENT
OF
INDIGENCY

Patient Information:
Name____ Account Number_____________

Address____

City____________________________________State_____________Zip_____________

Social Security Number_________-_____-_________
Birth Date ________/_______/_________ Country of Citizenship________________

IF THERE IS NO INCOME PLEASE PROVIDE THE FOLLOWING INFORMATION:

Are you disabled?____

How long have you been unemployed?____

When do you expect to go back to work?_____________________________________

Do you have dependents living with you? ___________________________________

Other information:____

Who is supporting you?____

____

Signature Verification of person providing Support:_______________________

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 and will take all action necessary to obtain assistance from the above sources. 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