Patient Financial Assistance

A. Hospital or Clinic Location

Select the location(s) where the patient received or will receive care:

- ☐ Henry Ford (HF) Hospital
- ☐ HF Kingswood Hospital
- ☐ HF Macomb Hospital
- ☐ HF Medical Centers
- ☐ HF Jackson Hospital
- ☐ HF West Bloomfield Hospital
- ☐ HF Wyandotte or HF Health Center Brownstown
- ☐ Other, please specify: _____

B. Patient Information

Complete this section about the patient receiving care:

Patient Name: _____

Date of Birth (DOB): _____ Medical Record Number: _____

Social Security Number: _____

Guarantor ID Number: _____

C. Responsible Party (Guarantor)

Complete this section about the person paying the medical bill:

Responsible Party Name (if different than section B): _____

Relationship to Patient: _____

Street Address: _____

City, State, Zip Code, Country: _____

Phone Number: _____ Work Phone Number: _____

Employer: _____ ☐ Full Time ☐ Part Time

D. Health Insurance Eligibility Verification

Select 'yes' or 'no' for each of the following questions:

1. Have you applied or been denied for Medicare?	☐ Yes	☐ No
a. Medicare Part A?	☐ Yes	☐ No
b. Medicare Part B?	☐ Yes	☐ No
c. Medicare Part C?	☐ Yes	☐ No
2. Have you applied or been denied for Medicaid?	☐ Yes	☐ No
a. If you were denied, was the denial within the last 90 days?	☐ Yes	☐ No
3. Are you applying for financial assistance services related to:		
a. Motor vehicle accident (MVA)?	☐ Yes	☐ No
b. Crime victim?	☐ Yes	☐ No
c. Workers compensation?	☐ Yes	☐ No
d. Other injury (for example, slip and fall)?	☐ Yes	☐ No
4. Does your employer or spouse's employer offer group health insurance?	☐ Yes	☐ No
5. Did you have coverage in the last 3 to 6 months through your employer or spouse's employer?	☐ Yes	☐ No
a. If yes, is COBRA available to you?	☐ Yes	☐ No
6. Do you have any other health insurance?	☐ Yes	☐ No
a. If yes, please provide the insurance information:		
7. Are you a permanent resident who lives within the Henry Ford Health service area?	☐ Yes	☐ No

E. Household Members and Household Employment Income

Complete this section about the patient's household:

How many people are in your household? _____

List any household member who earns an income (attach another sheet if needed):

Household Member Name	Relationship to Patient	Monthly Gross Income (before deductions)
		$
		$
		$
		$
		$
	Total Monthly Gross Income:	

F. Household Other Income

Complete this section about the patient's other income if these are other sources of income:

Other Income Sources	Amount Per Month
Child Support/Alimony	$
Foster Care, Township Trustee, Church Income, etc.	$
Pension, Social Security, Social Security Disability	$
Rental Property	$
Annuities, Interest, Retirement Distribution	$
Unemployment or Worker's Compensation	$
Other (please specify)	$
Total Other Income Sources	$

G. Household Assets

Complete this section about the patient's household assets if these are household assets:

Type of Asset	Total
Cash	$
Savings Account	$
Checking Account	$
Stocks	$
Bonds	$
Savings Bonds	$
Certificates of Deposit (CDs)	$
Money Market Accounts	$
Mutual Funds	$
Trusts	$
Total Assets	$

H. Monthly Household Expenses

Complete this section about the patient's household expenses if there are any household expenses:

Type of Expense	Amount Per Month
Rent	$
Mortgage	$
Child Support	$
Groceries	$
Vehicle Payment	$
General Bills	$
Total Monthly Household Expenses	$

I. Authorization

I hereby authorize the release of the information contained in this application to Henry Ford Health (HFH) for the determination of my eligibility status for financial assistance in accordance with HFH policies and procedures. I authorize HFH to verify this information as necessary, which may include but is not limited to, obtaining a credit bureau report, verifying employment and/or income, and obtaining appropriate supporting documents. All information and income documentation provided by me in this application is true, accurate and complete as shown. If it is determined at any time the information I provided was false or inaccurate, all financial assistance will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. I also agree to accept payment responsibility for any amount due after any partial financial assistance discounts.

Print Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Please verify that you have completed this document and provided all applicable documentation needed to process your request before you return your application:

- ☐ Completed all pages of application, including signature and date.
- ☐ Attached your most recent year Wage and Tax Statements (Form W-2) and or Miscellaneous Income (Form 1099.
- ☐ Attached last 2 months of pay stubs with year-to-date earnings for each member of the household.
- ☐ Attached your Federal Income Tax return for the most recent year (form 1040).
- ☐ Attached a copy of your Michigan driver's license or Michigan state identification card.
- ☐ Attached your last two months of recent bank statements: checking/savings.
- ☐ Attached proof of other income (or example: rental income, etc.)
- ☐ Attached copies of medical insurance cards if you have coverage.
- ☐ Attached a copy of the Medicaid denial letter if you applied and were denied.

Please note, a statement of personal financial need may be required to further evaluate your application.