Patient Financial Assistance Program
Henry Ford Health System

A Hospital or Clinic Location: *Please select the location(s) where the patient received care*

☐ Henry Ford Hospital ☐ HF Kingswood Hospital ☐ HF Macomb Hospitals
☐ HF Medical Centers ☐ HF West Bloomfield Hospital ☐ HF Wyandotte Hospital or HF Health Center Brownstown
☐ Other (Please specify: _____) ☐ Henry Ford Allegiance Health

B Patient Information: *Please complete this section about the patient who received* care

Patient Name: _____ DOB: _____

Social Security Number: _____ MRN: _____ Guarantor ID: _____

C Responsible Party (Guarantor): *Please complete this section about the person paying the medical bill*

Responsible Party Name: *(if different than Section B)* _____ Relationship to Patient: _____

Street Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____ County: _____

Employer: _____ ☐ Full-time ☐ Part-time Work Phone: _____

D Health Insurance Eligibility Verification

1. Are you eligible for Medicare? 1a. Medicare Part A 1b. Medicare Part B	 ☐ No ☐ Yes ☐ No ☐ Yes	5. Does your employer or spouse's employer offer group health insurance?	☐ No ☐ Yes
2. Are you eligible for Medicaid?	☐ No ☐ Yes	6. Did you have coverage in the past 3-6 months through an employer?	☐ No ☐ Yes
3. Are you applying for financial assistance for services related to: 3a. Motor Vehicle Accident (MVA) 3b. Crime Victim 3c. Workers' Compensation 3d. Other Injury (e.g., Slip and Fall)	 ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes	7. Are you eligible to apply for insurance through the Health Insurance Exchange?	☐ No ☐ Yes
4. Do you have any other health insurance?	☐ No ☐ Yes	8. Are you a U.S. citizen or legal resident?	☐ No ☐ Yes
4a. If yes, please specify the insurance company:			

E Household Members & Household Employment Income

How many people are in your household? _____

Please list any household member who earns an income (attach an additional sheet if necessary):

Household Member Name	Relationship to Applicant	Monthly Gross Income (before deduction)
		$
		$
		$
	Total Monthly Gross Income	$

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F Household Other Income (Non-Employment)

Other Income Sources	Amount per Month
Child Support	**$**
Foster Care, Township Trustee, Church Income, etc.	**$**
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

Type of Asset	Total
Cash	**$**
Savings Account	**$**
Checking Account	**$**
Health/Medical Savings Account	**$**
Liquid Assets (e.g., Stocks, Bonds, IRA, Certificates of Deposit)	**$**
Total Assets	**$**

H Authorization

I hereby authorize the release of the information contained in this application to Henry Ford Health System (HFHS) for the determination of my eligibility status for financial assistance in accordance with HFHS policies and procedures. I authorize HFHS 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 the following prior to returning your application:

☐ Completed all pages of application	☐ Included proof of income or letter of support	☐ Included proof of U.S. citizenship and/or legal residency
☐ Signed and dated application	☐ Included copies of medical insurance cards, if you have coverage	☐ Included a copy of the Medicaid denial letter, if you applied and were denied