MUNSON HEALTHCARE

Form 10570 06/24 English
Form 10572 06/24 Spanish

FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION (please print clearly and answer all questions completely)			
Patient's Legal Name:	**Preferred Name:**	**Birthdate:**	
Street Address/PO Box:	**City:**	**State:**	**Zip:**
Last 4 digits of SSN:	**Email Address:**	**Phone Number:**	
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ Other:_____			

HOUSEHOLD (List all people who live in your household other than yourself)			
Name	**Age**	**Relationship to Patient**	
Example: Jane Doe	*45*	*wife*	
1.			
2.			
3.			
4.			
5.			

INCOME (List <u>all</u> income for people who live in your household, excluding minors)			
Name	**Income Amount**	**How often? (weekly, monthly, yearly, etc.)**	**What type of income? (job, social security, VA, pension, worker's comp, odd jobs, alimony, etc.)**
Example: Jane Doe	*$500.00*	*monthly*	*Self-employment*
1.			
2.			
3.			
4.			

REQUIRED DOCUMENTS:

- A copy of your most recent Federal Income Tax forms (including all schedules).
- A copy of personal and/or business checking and savings bank statements for the most current three months (if married; joint and separate accounts). Not required for MHC Otsego Memorial Health accounts.
- A copy of the two most recent paystub(s) with year-to-date earnings.
- A copy of the Medicaid determination letter (if applicable). Not required for MHC Otsego Memorial Health accounts.

See boxes below for any other type of additional income.

Employment wages/salaries , pay stubs (W-2 not accepted)	Unemployment	Alimony	VA benefits
Social Security (before deductions) or benefit statement	Tribal per capita distribution	Gov't assistance	Annuities
Self-employment income records, and/or form 1099	Pension or retirement	Odd jobs	Rental property
Worker's compensation award letter	Cash receipts	Traditional IRA withdrawals	Any other income

***** If you are claiming no income, briefly explain how you are being supported and provide a written statement from the individual or organization stating how and to what degree they are supporting you.**

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ASSET QUESTIONS	YES	NO	COMMENTS
Do you file Federal Income Taxes? If no, explain.			
Do you have a personal checking and/or savings account? (circle which one(s) you have)			
Do you have a business checking and/or savings account? (circle which one(s) you have)			

INSURANCE QUESTIONS	YES	NO	COMMENTS
Do you have any health insurance? If so, please provide the name of the insurance.			
Do you currently have active Medicaid or a Medicaid Spend Down/deductible?			
Do you have a Health Savings Account (HSA)?			
Are you enrolled in a Healthcare Cost Sharing Program or Ministry? If yes, which program?			
Have you applied for Financial Assistance at any other MHC facility? If yes, which facility?			
Have you lost health insurance coverage within the last 90 days?			
Are you a Veteran?			
Was your medical service related to a work accident or an auto accident?			
If yes, please provide work or auto insurance company name and claim number:			

Medical Bills: Please check below if you have bills from any of these providers below:

- ☐ EMBCC
- ☐ Grand Traverse Radiologists
- ☐ Somnia Anesthesia
- ☐ Sound In-Patient Physicians
- ☐ Other: _____
- ☐ Grand Traverse Pathology
- ☐ Munson Anesthesia
- ☐ Traverse Heart and Vascular
- ☐ Cowell Family Cancer Center

Please call the phone number listed on each bill and inform the provider that you are applying for Munson's Financial Assistance Program. The provider may match Munson Healthcare's Financial Assistance determination.

CERTIFICATION: *By signing this document, I affirm the above information is correct to the best of my knowledge. I also understand that if the information submitted is determined to be false, this will result in a denial of the application and the account balance due will remain my responsibility. I further authorize Munson Healthcare and its subsidiaries to verify any information within the application. This may include using credit reporting agencies.*

PATIENT'S SIGNATURE: _____ **DATE:** _____

PARENT/LEGAL REPRESENTATIVE'S SIGNATURE (IF NOT PATIENT): _____ **DATE:** _____

MAIL OR EMAIL COMPLETED APPLICATIONS AND DOCUMENTATION TO:

Attention: Financial Assistance Dept.

- **Kalkaska Memorial Health Center, 419 S Coral St, Kalkaska, MI 49646**
- **MHC Cadillac Hospital, 400 Hobart St, Cadillac, MI 49601**
- **MHC Charlevoix Hospital, 14700 Lake Shore Dr, Charlevoix, MI 49720**
- **MHC Grayling Hospital, 1100 E Michigan Ave, Grayling, MI 49738**
- **MHC Manistee Hospital, 1465 E Parkdale Ave, Manistee, MI 49660**
- **MHC Otsego Memorial Hospital, 825 N Center Ave, Gaylord, MI 49735**
- **Munson Medical Center, 1105 Sixth St, Traverse City, MI 49684**
- **Paul Oliver Memorial Hospital, 224 Park Ave, Frankfort MI 49635**

EMAIL: MHC-financialassistance@mhc.net
For assistance, call 231-935-2350