Patient Financial Assistance Program

Henry Ford Health System

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

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

B Patient Information: *Please complete this section about the patient receiving* 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. Have you applied or been denied for Medicare or Medicaid?		4. Does your employer or spouse's employer offer group health insurance?	☐ No ☐ Yes
1a. Medicare Part A	☐ No ☐ Yes	4a. Did you have coverage in the last 3 to 6 months through your employer?	☐ No ☐ Yes
1b. Medicare Part B	☐ No ☐ Yes		
1c. Medicare Part C	☐ No ☐ Yes	**If yes,** is COBRA available?	☐ No ☐ Yes
1d. Medicaid	☐ No ☐ Yes		
If you were denied for Medicaid, was the denial within the last 90 days?	☐ No ☐ Yes		
2. Are you applying for financial assistance for services related to:		5. Do you have any other health insurance?	☐ No ☐ Yes
2a. Motor Vehicle Accident (MVA)	☐ No ☐ Yes	If yes, please provide the insurance information:	
2b. Crime Victim	☐ No ☐ Yes		
2c. Workers Compensation	☐ No ☐ Yes	6. Are you a permanent resident who lives within the Henry Ford Health System Service area?	☐ No ☐ Yes
2d. Other Injury (e.g. Slip and Fall)	☐ No ☐ Yes		

E Household Members & Household Employment Income

How many people are in your household? _____

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

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

F Household Other Income (Non-Employment)

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

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

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 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 and provided all applicable documentation needed to process your request prior to returning your application:

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

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