患者财务援助
Patient Financial Assistance

A. 医院或诊所地点
Hospital or Clinic Location

请选择患者接受或将要接受治疗的地点：
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 或 HF Health Center Brownstown
- ☐ 其他，请注明：_____
  Other, please specify:

B. 患者信息
Patient Information

请在本段填写有关接受护理的患者的信息：
Complete this section about the patient receiving care:

患者姓名：_____
Patient Name:

出生日期 (Date of Birth, DOB)：_____ 医疗记录编号：_____
Date of Birth (DOB): Medical Record Number:

社会安全号码：_____
Social Security Number:

担保人 ID 号码：_____
Guarantor ID Number:

C. 责任方（担保人）
Responsible Party (Guarantor)

请在本段填写有关医疗费用支付人的信息：
Complete this section about the person paying the medical bill:

责任方姓名（如与 B 部分不同，请填写）：_____
Responsible Party Name (if different than section B):

与患者的关系：_____
Relationship to Patient:

街道地址：_____
Street Address:

城市、州、邮编、国家：_____
City, State, Zip Code, Country:

办公电话：_____ 办公电话：_____
Phone Number: Work Phone Number:

雇主：_____ ☐ 全职 Full Time ☐ 兼职 Part Time
Employer:

D. 健康保险资格验证
Health Insurance Eligibility Verification

请对以下每个问题选择“是”或“否”：
Select ‘yes’ or ‘no’ for each of the following questions:

1. 您是否申请过 Medicare 或被其拒绝过？ Have you applied or been denied for Medicare?	☐ 是 Yes	☐ 否 No
a. Medicare A 部分？ Medicare Part A?	☐ 是 Yes	☐ 否 No
b. Medicare B 部分？ Medicare Part B?	☐ 是 Yes	☐ 否 No
c. Medicare C 部分？ Medicare Part C?	☐ 是 Yes	☐ 否 No
2. 您是否申请过 Medicaid 或被其拒绝过？ Have you applied or been denied for Medicaid?	☐ 是 Yes	☐ 否 No
a. 如果您被拒绝，拒绝时间是否在最近 90 天内？ If you were denied, was the denial within the last 90 days?	☐ 是 Yes	☐ 否 No
3. 您是否在申请与以下方面相关的援助服务？ Are you applying for financial assistance services related to: a. 机动车交通事故 (Motor vehicle accident, MVA)？ Motor vehicle accident (MVA)?	☐ 是 Yes	☐ 否 No
b. 犯罪受害者？ Crime victim?	☐ 是 Yes	☐ 否 No
c. 工伤赔偿？ Workers compensation?	☐ 是 Yes	☐ 否 No
d. 其他伤害（例如滑倒和跌倒）？ Other injury (for example, slip and fall)?	☐ 是 Yes	☐ 否 No
4. 您或您配偶的雇主是否提供团体健康保险？ Does your employer or spouse’s employer offer group health insurance?	☐ 是 Yes	☐ 否 No
5. 您在最近 3 至 6 个月内是否已通过您或您配偶的雇主获取保险？ Did you have coverage in the last 3 to 6 months through your employer or spouse’s employer?	☐ 是 Yes	☐ 否 No
a. 如勾选“是”，您是否可以享受《统一综合预算调节法案》(Consolidated Omnibus Budget Reconciliation Act, COBRA) 的福利？ If yes, is COBRA available to you?	☐ 是 Yes	☐ 否 No

6. 您是否还参加了其他健康保险？
Do you have any other health insurance? ☐ 是 Yes ☐ 否 No

a. 如勾选“是”，请提供保险信息：
If yes, please provide the insurance information:

7. 您是住在 Henry Ford Health 服务区域内的永久居民吗？
Are you a permanent resident who lives within the Henry Ford Health service area? ☐ 是 Yes ☐ 否 No

E. 家庭成员和家庭就业收入
Household Members and Household Employment Income

请填写本部分有关患者家庭的信息：
Complete this section about the patient's household:

您家有几口人？_____
How many people are in your household?

请列出任何有收入的家庭成员（如有需要，请另附一张纸）：
List any household member who earns an income (attach another sheet if needed):

家庭成员姓名 Household Member Name	与患者的关系 Relationship to Patient	每月总收入（扣税前） Monthly Gross Income (before deductions)
		$
		$
		$
		$
		$
	每月总收入： Total Monthly Gross Income:	

F. 家庭其他收入
Household Other Income

如果患者有其他收入来源，请填写本部分有关患者其他收入的信息：
Complete this section about the patient's other income if these are other sources of income:

其他收入来源 Other Income Sources	每月金额 Amount Per Month
子女抚养费/赡养费 Child Support/Alimony	$
家庭寄养、城镇受托人、教会收入等 Foster Care, Township Trustee, Church Income, etc.	$

养老金、社会保险、残疾人社会保险 Pension, Social Security, Social Security Disability	$
房屋出租 Rental Property	$
年金、利息、退休金分配 Annuities, Interest, Retirement Distribution	$
失业补偿或工伤赔偿 Unemployment or Worker's Compensation	$
其他（请注明） Other (please specify)	$
其他收入来源总计 Total Other Income Sources	$

G. 家庭资产
Household Assets

如果有家庭资产，请填写本部分有关患者家庭资产的信息：
Complete this section about the patient's household assets if these are household assets:

资产类型 Type of Asset	总计 Total
现金 Cash	$
储蓄账户 Savings Account	$
支票账户 Checking Account	$
股票 Stocks	$
债券 Bonds	$
储蓄债券 Savings Bonds	$
定期存款 (Certificates of Deposit, CD) Certificates of Deposit (CDs)	$
货币市场账户 Money Market Accounts	$
共同基金 Mutual Funds	$
信托基金 Trusts	$
总资产 Total Assets	$

H. 每月家庭支出
Monthly Household Expenses

如果有家庭支出，请填写本部分有关患者家庭支出的信息：
Complete this section about the patient's household expenses if there are any household expenses:

支出类型 Type of Expense	每月金额 Amount Per Month
租金 Rent	$
抵押货款 Mortgage	$
子女抚养费 Child Support	$
生活用品 Groceries	$
养车费用 Vehicle Payment	$
一般费用 General Bills	$
每月家庭总支出 Total Monthly Household Expenses	$

I. 授权声明
Authorization

本人特此授权 Henry Ford Health (HFH) 根据 HFH 的政策和程序公开本申请表中的信息，以确定本人是否有资格获得援助。本人授权 HFH 在必要时验证这些信息，其采用的措施包括但不限于获得征信机构报告、核实就业情况和/或收入，以及获取相关证明文件。本人在此申请书中提供的所有信息及收入证明文件均真实、准确、完整。如果 HFH 在任何时候确定本人提供了虚假或不准确的信息，则本人所有的财务援助都将撤销，并且本人将负责立即全额支付任何或全部未结清余额。本人也同意承担任何部分财务援助折扣后任何应付款项的支付责任。

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.

正楷姓名：_____
Print Name:

与患者的关系：_____
Relationship to Patient:

签名：_____
Signature:

日期：_____
Date:

在交回申请之前，请确认您已填写本文件并提供处理申请所需的所有适用文件：
Please verify that you have completed this document and provided all applicable documentation needed to process your request before you return your application:

- ☐ 已填妥申请表的所有页面，包括签名和日期。
  Completed all pages of application, including signature and date.

- ☐ 已随附您最近一年的工资和税单（表 W-2）和杂项收入（表 1099）。
  Attached your most recent year Wage and Tax Statements (Form W-2) and or Miscellaneous Income (Form 1099).

- ☐ 已随附最近两个月的工资单，其中包含每位家庭成员年初至今的收入。
  Attached last 2 months of pay stubs with year-to-date earnings for each member of the household.

- ☐ 已随附您最近一年的联邦所得税退税信息（表 1040）。
  Attached your Federal Income Tax return for the most recent year (form 1040).

- ☐ 已随附密歇根州驾驶执照或密歇根州身份证副本。
  Attached a copy of your Michigan driver's license or Michigan state identification card.

- ☐ 已随附您最近两个月的银行对账单：支票/存款。
  Attached your last two months of recent bank statements: checking/savings.

- ☐ 已随附其他收入证明（例如，房租收入等）。
  Attached proof of other income (or example: rental income, etc.)

- ☐ 如果您有医疗保险，则已随附医疗保险卡副本。
  Attached copies of medical insurance cards if you have coverage.

- ☐ 已随附 Medicaid 拒绝函副本（如果您已申请并遭到拒绝）。
  Attached a copy of the Medicaid denial letter if you applied and were denied.

请注意，为便于进一步评估您的申请，您可能需要提供一份个人财务需求声明。
Please note, a statement of personal financial need may be required to further evaluate your application.