[Date]

Dear Patient/Applicant,

Henry Ford Health is driven by compassion and dedicated to providing personalized care for all – especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for all of your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete both sides, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us – you may not need to complete a new application. Unfortunately, we are unable to rely on a prior application that is greater than six months old.

Along with the application, you will need to provide verification of your household's income and verification of all assets owned by any household member.

Examples of proof of income and assets include:

- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Copy of receipt of unemployment benefits
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- Other income validation documents

Examples of proof of assets include:

- Current bank statements (checking and savings accounts) from last 3 months
- Investments, including stocks and bonds
- Trust funds
- Money market accounts
- Mutual funds

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you do not receive assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, we may be able to consider your outstanding medical bills to qualify you for financial assistance. If you would like for us to consider this, please also provide documentation of your outstanding monthly medical and pharmacy/drug costs, such as current invoices or statements of account balances. **Please know that the 1) completed application along with 2) proof of income, 3) assets, and 4) outstanding medical bills (if applicable) must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.**

When submitting your application, please keep in mind that communications via email over the internet are not secure. Although it may be unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed. We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

Please print and mail or hand deliver your completed application and supporting documentation to the following address:

Facility/Office where service was provided	Mail Completed Applications to:
Henry Ford St. John Hospital	3179 Solution Center, Chicago, IL 60677-3001
Henry Ford Warren Hospital	3179 Solution Center, Chicago, IL 60677-3001
Henry Ford Madison Heights Hospital	3179 Solution Center, Chicago, IL 60677-3001
Henry Ford Providence Novi Hospital	3179 Solution Center, Chicago, IL 60677-3001
Henry Ford Providence Southfield Hospital	3179 Solution Center, Chicago, IL 60677-3001
Henry Ford River District Hospital	3179 Solution Center, Chicago, IL 60677-3001
Henry Ford SEMI Medical Group	PO BOX 80278, Indianapolis, IN 46240

We are here to help and want to ensure that patients that qualify for financial assistance receive it. If you have any questions about this application, supporting documents required, or how to best get your application to us, please call one of our Patient Representatives at

Facility where service was provided	Phone #
Henry Ford St. John Hospital	877-809-6191
Henry Ford Warren Hospital	888-329-0421
Henry Ford Madison Heights Hospital	888-329-0421
Henry Ford Providence Novi Hospital	800-878-2455
Henry Ford Providence Southfield Hospital	800-878-2455
Henry Ford River District Hospital	888-329-0421

Sincerely,

Patient Financial Services
Henry Ford Health

Financial assistance application form

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date_____ Account number _____Hospital name_____

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Number of adults and children living in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____
Applicant spouse income _____
Social security benefits _____
Pension/retirement income _____
Disability income _____
Unemployment compensation _____
Worker's compensation _____
Interest/dividend income _____

Child support received _____
Alimony received _____
Rental property income _____
Food stamps _____
Trust fund distribution received _____
Other income _____
Other income _____
Total gross monthly income $ _____

Monthly living expenses

Mortgage/rent _____
Utilities _____
Phone (landline) _____
Cell phone _____
Groceries/food _____
Cable/internet/satellite tv _____
Car payment _____
Child care _____

Child support/alimony _____
Credit cards _____
Doctor/hospital bills _____
Car/auto insurance _____
Home/property insurance _____
Medical/health insurance _____
Life insurance _____
Other monthly expense _____
Total monthly expenses $ _____

Assets

Cash/savings/checking accounts _____
Stocks/bonds/investments/CD(s) _____
Other real estate/secondary residence _____
Boat/RV/motorcycle/recreational vehicle _____
Collector automobiles/non-essential automobiles _____
Other assets _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Signature of Applicant _____

Date _____

Comments _____

Letter of support

Patient medical record number/account number_____

Supporter's name_____

Relationship to patient/applicant _____

Supporter's address _____

To Henry Ford Health:

This letter is to advise that (patient's name)_____ receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter_____

Date _____