



# Financial Assistance Application

\*Please complete both sides of this form, sign and date.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Patient)

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Guarantor/Responsible Party)

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(Guarantor/Responsible Party)

Telephone: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of Dependent Children: \_\_\_\_\_

## MONTHLY INCOME

Patient's Employer: \_\_\_\_\_ Self-employed  Spouse/Parent Employer: \_\_\_\_\_ Self-employed

How long \_\_\_\_\_ to \_\_\_\_\_ Gross Wages \$ \_\_\_\_\_ How long \_\_\_\_\_ to \_\_\_\_\_ Gross Wages \$ \_\_\_\_\_

Unemployed  How long? \_\_\_\_\_ Unemployed  How long? \_\_\_\_\_

Social Security ..... \$ \_\_\_\_\_ Social Security ..... \$ \_\_\_\_\_

Unemployment Comp ..... \$ \_\_\_\_\_ Unemployment Comp ..... \$ \_\_\_\_\_

Worker's Comp ..... \$ \_\_\_\_\_ Worker's Comp ..... \$ \_\_\_\_\_

Child Support/Alimony ..... \$ \_\_\_\_\_ Child Support/Alimony ..... \$ \_\_\_\_\_

Other Income ..... \$ \_\_\_\_\_ Other Income ..... \$ \_\_\_\_\_

Source: \_\_\_\_\_

Source: \_\_\_\_\_

TOTAL: \$ \_\_\_\_\_

TOTAL: \$ \_\_\_\_\_

## ASSETS

Savings: \$ \_\_\_\_\_

Cash on Hand: \$ \_\_\_\_\_

Institution: \_\_\_\_\_

Stocks or Bonds: \$ \_\_\_\_\_

Checking: \$ \_\_\_\_\_

Institution: \_\_\_\_\_

Other Assets: \_\_\_\_\_

**DEBTS / EXPENSES**

Liabilities:	To Whom:	Monthly Payment:	Balance:
Mortgage/Rent	_____	_____	_____
Real Estate Prop.	_____	_____	_____
Bank Loan	_____	_____	_____
Auto Loan	_____	_____	_____
Credit Cards	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other Expenses	_____	_____	_____
	_____	_____	_____

\*\* PLEASE USE THIS SPACE TO DESCRIBE YOUR PERSONAL SITUATION AND YOUR REASONS FOR REQUESTING ASSISTANCE.

**The following documents must be provided for guarantor of account:**

- Federal Income Tax Return from 2016
- Proof of Medicaid denial for assistance
- Current Bank Statement (Past 90 days)
- Account Statement for CD, Money Market, Stocks, Bonds, etc.
- Current Pay Check Stub (s)
- Statement of income from other sources (Social Security, Pension, Workers Compensation, etc.)

This is to advise that I have pursued all other avenues possible for payment, including private insurance, governmental and charitable agencies providing funding and relief from financial obligations; therefore, I hereby request that Deckerville Community Hospital make a determination of my eligibility for their Charity Care Program. I understand that the information I submit concerning my income, family size, assets, expenses, and medical bills is subject to verification by Deckerville Community Hospital. I also understand that if the information I submit is now or at any time in the future determined to be false, such a determination will result in current and/or retroactive denial of Charity Care and I will be liable for charges for services rendered. I certify that all of the information in this form is true and correct. Incomplete or fraudulent application will be denied.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\*\*Please return this application to: Deckerville Community Hospital, Patient Financial Representative,  
3559 Pine Street, Deckerville, MI 48427 Phone No. (810) 376-7013