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 []

How long _____ to _____ Gross Wages $_____

Unemployed [] How long? _____

Social Security …….. $_____

Unemployment Comp …… $ _____

Worker's Comp …… $ _____

Child Support/Alimony …… $ _____

Other Income …… $ _____

Source: _____

TOTAL: $ _____

Spouse/Parent Employer: _____ Self-employed []

How long _____ to _____ Gross Wages $_____

Unemployed [] How long? _____

Social Security …….. $_____

Unemployment Comp …… $ _____

Worker's Comp …… $ _____

Child Support/Alimony …… $ _____

Other Income …… $ _____

Source: _____

TOTAL: $ _____

ASSETS

Savings: $ _____

Institution: _____

Checking: $ _____

Institution: _____

Other Assets: _____

Cash on Hand: $ _____

Stocks or Bonds: $ _____

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 2019
- Proof of Medicaid denial for assistance (*Hospital Service Only; NOT required for RHC services*)
- Current Bank Statement (Past 90 days)
- 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