McKENZIE HEALTH SYSTEM
Experience Our Difference

FINANCIAL ASSISTANCE APPLICATION

____ **I have applied for Medicaid and/or Healthy Michigan within the last 6 months and been denied (attach copy of denial letter)**

Or

____ **My family income exceeds (is more than) the Medicaid income limit of 133% of the Federal Poverty Guidelines.**

Patient Name_____ Birth Date_____

Dates of Service/Account Numbers_____

_____

Address_____

City_____ State_____ Zip_____

Phone Number(s)_____

Health Insurance: _____ No _____Yes, please specify_____

Health Savings Account: _____No _____Yes, please specify_____

All Persons Living in Household (include persons related by birth, marriage, or adoption):

Relationship to Patient	Last Name, First Name	Birth Date
Self	(same as above)	(see above)
Spouse		
Specify:		
Specify:		
Specify:		

Employment and Income History for the last 12 months

▲Person # 1 (self) _____

Source(s) of Gross Income/Before Taxes (please check all that apply)

___ **Current Employment**: Place of Employment_____
Estimated Annual Salary $_____ Start Date_____ Full or Part time?_____

___ **Previous Employment**: Former Place of Employment_____
Last date worked_____ Reason for leaving_____

___ **Unemployment or Workers Compensation**. Start Date_____ End Date:_____
Amount every 2 wks $_____

___ **Social Security, SSI or Disability Benefits**. Amount per month $_____
Have you ever applied?_____ Been denied?_____ Appeal Status?_____

___ **Pension, Retirement, Veterans or Survivor benefits**. Amount per month $_____

___ **Other Income (Rents, Odd Jobs, Royalties, Trusts/Estates, Public Assistance).**
Average amount per month $_____

___ **Child Support or Alimony**. Amount per month $_____

___ **Money from friends or relatives**. Average amount per month $_____

___ **None** (if none, please explain how you get funds to pay your routine monthly expenses like cell phone, rent, food, etc)_____

▲Person # 2 (spouse/other:_____)

___ **Current Employment**: Place of Employment_____
Estimated Annual Salary $_____ Start Date_____ Full or Part time?_____

___ **Previous Employment**: Former Place of Employment_____
Last date worked_____ Reason for leaving_____

___ **Unemployment or Workers Compensation** . Start Date_____ End Date:_____
Amount every 2 wks $_____

___ **Social Security, SSI or Disability Benefits**. Amount per month $_____
Have you ever applied?_____ Been denied?_____ Appeal Status?_____

___ **Pension, Retirement, Veterans or Survivor benefits**. Amount per month $_____

___ **Other Income (Rents, Odd Jobs, Royalties, Trusts/Estates, Public Assistance).**
Average amount per month $_____

___ **Child Support or Alimony**. Amount per month $_____

___ **Money from friends or relatives**. Average amount per month $_____

Asset Information (with your name or your spouses name on account, including joint accounts). Retirement savings accounts, college savings accounts and life insurance with a cash value do **NOT** count as assets.

___ Checking Account Name of Bank:_____ Balance $_____

___ Savings Account Name of Bank:_____ Balance $_____

___ Other (CD, money market, bonds, stocks, health savings account)_____

_____

___ None → There are no accounts with my name or spouses name on them. Initials_____

Documentation Requirements:

Please be sure to attach copies of written documentation to support all of financial information on this application including:

- **Copies of pay check stubs or direct deposit statements** (need at least one for all jobs held in last 12 months, unemployment, retirement/social security, etc)
- **Copies of last year's tax return**
- **Copies of bank statements** for checking, savings, health savings account (including those funded by a 3rd party/employer), CD's, bonds, stocks, mutual funds, trusts, etc)

I certify that the facts written on this application or told to a third party on my behalf as part of completing this charity care application are true and complete.

I understand that legal action may be taken if I have intentionally given false or misleading information, misrepresented, hidden or withheld facts that may cause me to receive charity assistance/discounts that I should not receive or more assistance/discounts than I should have received. I may be prosecuted for fraud and/or be required to repay the amount wrongfully received.

Person #1 (self) signature:_____ Date:_____

Person #2 (spouse) signature:_____ Date:_____

Mail Completed Application Packet to: McKenzie Health System
Attn: Financial Services Department
120 Delaware Street
Sandusky, MI 48471

For more information, please contact the Financial Services Department at 810-648-6119