MRH Marlette Regional Hospital
an affiliate of
UNITED HEALTHCARE PARTNERS

2770 Main Street | P.O. Box 307 | Marlette, MI 48453
marletteregionalhospital.org | 989-635-4000

Dear Patient/Guarantor:

Thank you for choosing Marlette Regional Hospital for your health care needs. It is our mission and privilege to offer financial assistance to our patients to ensure quality of health for those we serve.

At your request, we have enclosed our B.C.U.P.S. program grant application. This grant provides $500 in financial assistance for those undergoing treatment for breast cancer, and patients are eligible to reapply for funding every 6 months. Applicants must be a resident of Huron, Lapeer, Sanilac or Tuscola County.

In order for us to process your financial request, the following documents are required:

- **A completed application (enclosed);**
- **A copy of your state issued driver's license or identification card;**
- **A copy of documentation showing breast cancer diagnosis.**

The completed application including all required documentation must be received for consideration.

Mail completed application and documentation to:

Marlette Regional Hospital
Patient Accounting Department
ATTN: B.C.U.P.S. Program Grant
P.O. Box 307
Marlette, MI 48453

If you have any questions please contact the Patient Accounting Department at 989-635-4232 Monday through Friday 7:00 a.m. – 3:30 p.m.

Respectfully,

Marlette Regional Hospital
B.C.U.P.S. Program Committee

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B.C.U.P.S PROGRAM GRANT APPLICATION

PATIENT INFORMATION

Patient Name: ________________________________ **Birth Date:** ____________

Marital Status: (circle): S M D W

Patient Address: ____
City/State/Zip Code: ____
County of Residence: ____
Primary Phone: ______________________ **Alternate Phone:** ________________

PHYSICIAN INFORMATION

Physician Name: ____
Office Phone: ________________________ **Diagnosis:** ____________________

My signature on this form certifies that all statements are true to the best of my knowledge. I understand that this grant is limited to $500, but I can reapply for additional grant funding every 6 months while undergoing treatment for breast cancer. I agree to allow Marlette Regional Hospital or its representative to validate all information provided.

PLEASE SIGN BELOW:

____
Print Patient Name / Guardian **DATE**

____
Signature Patient / Guardian **DATE**