Marlette Regional Hospital

Updated 3/30/2020

Dear Patient/Guarantor:

Thank you for choosing Marlette Regional Hospital for your healthcare needs. It is our mission and privilege to offer financial assistance to our patients.

At your request, we have provided the enclosed Financial Assistance Application. In order for us to evaluate your financial situation, the following documents are required:

- A completed Financial Assistance Application (enclosed);
- A copy of your most current Federal tax from(s) with ALL schedules, including W-2's;
- A copy of your most recent three (3) paycheck stubs for you and anyone working within your household;
- Medicaid denial;
- Other:_____

Incomplete applications will not be processed for assistance. The completed application including all documentation must be received for consideration.

Mail completed application and documentation to:

Marlette Regional Hospital
ATTN: Patient Accounting Department
2770 Main Street, P.O. Box 307
Marlette, MI 48453

If you have any questions, please contact our Patient Accounting Department at 989-635-4042 Monday through Friday 7:00 AM – 4:30 PM.

Respectfully,

Patient Accounting Department

FINANCIAL ASSISTANCE APPLICATION

Account Number:_____

PATIENT INFORMATION

Patient Name: _____**Birth Date:**_____

Marital Status: (circle): S M D W

Patient Address: _____
City/State/ZIP:_____
Primary Phone:_____ **Alternate Phone:**_____
Spouse's Name: _____ **Spouse Primary Phone:**_____
Medical Insurance: _____
Medical Insurance Application in Process*_____

RELATIVE/OTHER CONTACT INFORMATION TO CONFIRM FINANCIAL SUPPORT

Relative/Other Contact Name: _____ **Relationship:**_____
Primary Phone: _____ **Alternate Phone:** _____

EMPLOYMENT AND INCOME INFORMATION

Number of Taxable Dependents:_____ **Number of Children Aged 18 and Under:**_____
Patient's Employer(s):_____
Hire Date:_____ **Work Phone:**_____
Avg Hours Worked Weekly _____ **Hourly Wage:**_____
Spouse's Employer(s): _____**Hire Date:** _____
Avg Hours Worked Weekly: _____ **Hourly Wage:** _____

If you own a business or are self-employed, describe the business:

Uninsured patients may be denied Financial Assistance if they are determined to be "non-cooperative" with attempts to obtain insurance or eligibility coverage through other programs (for example – Medicaid)

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REQUIRED DOCUMENTATION & CERTIFICATION

In order to process your Financial Assistance Application, you must provide a copy of the following items:

- Copy of Official picture Identification – Driver's License or State ID and
- Income Verification – (i.e., Current Pay stub; Tax Return)
  - Alimony Received $_____
  - Child Support Received $_____
  - Social Security Received $_____
  - Pensions $_____
  - Unemployment Income $_____
  - Disability Received $_____
  - Public Assistance (bridge card benefits) $_____
- Letter of Support – Signed by the party who is helping you with living and/or shelter support

CERTIFICATION

My signature on this form certifies that all the statements are true to the best of my knowledge and that I have disclosed all facts concerning my finances. I understand and acknowledge that any misrepresentation of my finances in connection with this Application, or any failure to cooperate with efforts to qualify me for programs which may cover the cost of my care (for example Medicaid, personal injury claim, workers compensation, auto claims) may invalidate any award of Financial Assistance and that I will be financially liable for the services provided. I agree to allow Marlette Regional Hospital or its representative to validate all information provided.

I understand that if I qualify for partial financial assistance I will be responsible for payment of the remaining portion of my bill.

PLEASE SIGN BELOW:

Print Patient Name / Guardian **DATE**

Signature Patient / Guardian **DATE**