



HRMC

Huron Regional Medical Center

FINANCIAL ASSISTANCE APPLICATION

In order to determine what type of payment plan will apply to your financial situation, we ask that you complete and return this form to Huron Regional Medical Center by: _____

Marital Status: Single Married Separated Divorced Widowed

APPLICANT/PATIENT

Name _____
 Address _____
 Social Security # _____ - _____ - _____
 Current Employer _____
 Hourly Wage _____

Home Phone /Cell _____
 City/State _____ Zip _____
 Date of Birth _____ / _____ / _____
 Work Phone _____
 Hours per Week _____

SPOUSE OR OTHER ADULTS OVER 18 LIVING IN HOUSEHOLD

Name _____
 Address _____
 Social Security # _____ - _____ - _____
 Current Employer _____
 Hourly Wage _____

Home Phone/Cell phone _____
 City/State _____ Zip _____
 Date of Birth _____ / _____ / _____
 Work Phone _____
 Hours per Week _____

Please list all dependents living in your household:

Name	Date of Birth	Social Security #	Relationship to Applicant

Income/Assets

Total Monthly Household Income

Wages/Salary (Gross) \$ _____
Income from Self-employment \$ _____
Income from Retirement \$ _____
Income from Disability/SS \$ _____
Income from Unemployment \$ _____
Income from Worker's Comp \$ _____
Child Support/Alimony \$ _____
Monthly Food Stamp Amount \$ _____
Heating Assistance \$ _____
Rental Assistance \$ _____
Other Income \$ _____

Total Assets

Checking Account \$ _____
Bank: _____
Savings Account \$ _____
Bank: _____
Investments: \$ _____
(Non-retirement)
IRA(s) \$ _____
401K \$ _____
Homestead Value \$ _____
Other Property Value \$ _____
Automobile Value \$ _____
Boat, Camper, etc. \$ _____
Other Assets \$ _____

Balance/Value

Total Monthly Expenses

House Payment/Rent \$ _____
Property Taxes \$ _____
Property/Rental Insurance \$ _____
Credit Cards \$ _____
Bank Loans \$ _____
Pay Day Loans \$ _____
Rent to Own \$ _____
Car/Truck Payments \$ _____
Auto Insurance \$ _____
Gas/other Auto expenses \$ _____
Child Support \$ _____
Daycare \$ _____
Phone/cell phone \$ _____
Cable TV \$ _____
Internet \$ _____
Electricity/Gas \$ _____
Water/Sewer/Garbage \$ _____

Medical Bills \$ _____
Prescriptions \$ _____
Life/Health Ins. \$ _____
Groceries \$ _____
Other Expenses \$ _____

Additional Information:

1. Have you ever declared bankruptcy? Yes/No. If Yes, when: _____
2. Do you have any judgments or liens filed against you? If yes please provide date and reason: _____
3. During the past 12 months, have you received any benefits such as Medicaid, food stamps, emergency energy assistance, County Poor Relief, etc.? If yes please describe _____
4. What is the approximate amount of all outstanding medical bills you owe, (include, hospital, clinic, dental, etc.) _____
5. Do you have health insurance coverage? Yes/No. If so please provide a copy of your ID card.
6. Did you apply for insurance coverage through the Affordable Care Act? Yes/No. If No explain why you did not apply. _____ If Yes, do you have coverage? Yes/No. If No provide documentation as to why you do not have coverage.
7. Other comments: Please inform us of any additional information you would like us to consider with your application. _____

ASSIGNMENT OF RIGHTS: Please read carefully:

By signing below I/we agree that the information and statements contained in this Application for Financial Assistance along with the supporting documentation which I/we submitted is accurate, true and correct to the best of my knowledge.

I/we understand that Huron Regional Medical Center may make reasonable requests for additional information and verification if necessary.

I/we understand that the information I/we have provided will be kept confidential by Huron Regional Medical Center.

I/we understand Huron Regional Medical Center makes no representation that financial assistance is guaranteed.

I/we hereby agree the above information is correct and I/we authorize Huron Regional Medical Center to verify this information.

___ I/we have enclosed copies of the last 60 days of pay stubs for all wage earners contributing to household income.

___ I/we have enclosed a complete copy of the most recent tax return.

Patient Signature

Date

Spouse Signature

Date