Application for Financial Assistance

To qualify for financial assistance, you have up to 240 days after you receive your first bill to complete this application and provide supporting documents. If you have any questions, please call us toll free at (844) 832-1956. Please mail, bring or fax the completed form and supporting documents to: MidMichigan Health Business Office, 4000 Wellness Drive, Midland, MI 48670 | Fax (989) 633-5241

Application Information: (Please provide full legal name)

Name | Date of Birth

Mailing Address

City | State | Zip | Phone

Employer | If unemployed, list the last date of employment

Spouses Information (Please provide full legal name)

Name | Date of Birth

Employer | If unemployed, list the last date of employment

Household Members

How many members are living in your household? (Include yourself, your spouse, children ,an any other dependent living in the same household)

Dependents Legal Name	Age	Date of Birth	Relationship to Applicant

Household Income Information (Please list ALL forms of income before deductions)

Source of Income	Amount	Frequency of Payment

Please list the total household income received in the last 3 months

1. Please attach proof of income (pay stubs and tax returns).
2. If you listed zero income, please attach a written explanation as to who provides your room and board.
3. For Social Security recipients: Please provide your current Social Security benefit letter, (before Medicare deduction).

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature › | Date

OFFICE USE ONLY

Authorized by › | Date

MidMichigan Health
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