Eaton Rapids Medical Center

Patient Financial Support Application

Income Verification: Please provide copies of the following documents to verify your income:	
1. Copy of Medicaid denial letter (ALL pages)	4. Last 2 concurrent pay stubs
2. Prior years filed income tax	5. Social security and/or pension
3. Prior years w-2 or 1099	6. Most Recent Bank Statement

Household Member Information:			
Please list household members below:		Number in household based on tax returns:	
1.		Date of Birth:	
2.		Date of Birth:	
3.		Date of Birth:	
4.		Date of Birth:	
5.		Date of Birth:	
Total Gross Income from all household members:			

Patient Information:		
Name:	Age:	Home Phone:
Address:		Alternate Phone:
		Employer:
Spouse/Parent of Minor:		Relationship:
Address (if different):		Employer:
		Contact Phone:

Monthly Gross Income		Monthly Obligations	
Applicants Wages	$	Mortgage/Rent	$
SpousesWages	$	Electric	$
Social Security Disability	$	Gas	$
Pension	$	Water	$
VA Benefits	$	Phone:	$
Public Assistance	$	Cell Phone:	$
Unemployment	$	Internet	$
Supplemental Income	$	Cable	$
Alimony/Child Support	$	Auto Insurance	$
Dividends/Interest	$	Car Payment	$
Income from Real Estate	$	Other:	$
Other:	$	Other:	$
If $0 income, Statement of Zero Income Form required			
Total Monthly Income:	$	Total Obligations:	$

Any additional information or comments:

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Assets			
Cash on Hand	$	Stocks/Bonds	$
House/Property	$	Real Estate (Other than primary)	$
Checking/Savings/IRA	$	Lump Sum Payments	S

Motor Vehicles(s) Automobiles, Motorcycles, Campers/RV, Boats, etc				
Type	Make	Model	Year	Value

I hereby certify that the information provided above is true to the best of my knowledge.

Signature:	Date:

OFFICE USE ONLY			
Preliminary Determination			
Accounts in Review:	1.	2.	3.
	4.	5.	6.
Total Outstanding Balance:	$		
Date submitted to Patient Accounts:			
Returned for more information:			

OFFICE USE ONLY				
Final Determination				
Patient Insured	☐ Yes	☐ No	Type of Insurance:	
Monthly Income	$		Number of Dependents:	
Poverty Level %			Expected Payment %	
APPROVED / DECLINED (up to $4,999)			Reason: Per Policy 20.01.11 guidelines.	
Reviewed by Pt Accts Manager	Date:		Signature:	
APPROVED / DECLINED (up to $5,000)			Reason:	
Reviewed by CFO	Date:		Signature:	

Notes added to Meditech	Date:
Emailed Employee Charity Group	Date: