Munson Healthcare Otsego Memorial Hospital
Financial Assistance Application

I. RESPONSIBLE PARTY				**SSN** _____
LAST NAME	FIRST NAME	MI	MARITAL STATUS	DATE OF BIRTH
STREET ADDRESS			PO BOX	
CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?	HOME PHONE
ARE YOU EMPLOYED? ____YES ____NO	____FULL-TIME	____PART-TIME	____SEASONAL	
EMPLOYER NAME AND ADDRESS				YEARS EMPLOYED _____
DO YOU FILE TAXES? _____YES _____NO	ARE YOU *RECEIVING* OR HAVE YOU *APPLIED* FOR SOCIAL **SECURITY DISABILITY** PAYMENTS?			

II. SPOUSE OR SIGNIFICANT OTHER			**SSN** _____
NAME			DATE OF BIRTH
ARE YOU EMPLOYED? ____YES ____NO	____FULL-TIME	____PART-TIME	____SEASONAL
EMPLOYER'S NAME AND ADDRESS			YEARS EMPLOYED _____
DO YOU FILE TAXES _____YES _____NO	ARE YOU *RECEIVING* OR HAVE YOU *APPLIED* FOR SOCIAL **SECURITY DISABILITY** PAYMENTS?		

III. HOUSEHOLD INFORMATION (ALL OTHER PERSONS IN HOUSEHOLD)		
NAME	DOB	RELATIONSHIP
TOTAL PERSONS IN HOUSEHOLD:		

IV. MONTHLY INCOME		
RESPONSIBLE PARTY'S MONTHLY INCOME		$
SPOUSE/SIGNIFICANT OTHER'S MONTHLY INCOME	+	$
TOTAL MONTHLY INCOME:	=	**$**

V. HAVE YOU BEEN APPROVED FOR MEDICAID?	Yes NO
FILL IN SPENDDOWN AMOUNT IF APPLICABLE	APPROVED SPENDDOWN AMOUNT

VI. MISCELLANEOUS INCOME PER MONTH – complete All fields with gross monthly amount or N/A if not applicable			
DIVIDENDS, INTEREST	$	PENSIONS	$
SOCIAL SECURITY	$	INVESTMENT/RENTAL INCOME	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	GRANTS	$
CHILD SUPPORT/ALIMONY	$	Other	$
TOTAL MONTHLY MISCELLANEOUS INCOME:	$		
MONTHLY INCOME:	+		$
TOTAL MONTHLY INCOME:	= $	**ANNUAL:**	$

ALL INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED AND FOLLOW THE PROCEDURE GUIDELINES DEFINED IN THE FINANCIAL ASSISTANCE POLICY

YOU ARE REQUIRED TO NOTIFY MUNSON OMH OF ANY INCOME CHANGES DURING YOUR APPROVAL PERIOD

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL OR ITS AGENTS.

SIGNATURE/ DATE: _____/_____

RELATIONSHIP IF OTHER THAN PATIENT:

FOR OFFICE USE ONLY

APPROVED/DENIED	%	$	DATE:
APPROVED BY:			

Approved applications will be effective for services covered according to Financial Assistance Policy guidelines for up to one (1) year from the approval date.

The following documents are required (if applicable):

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Spousal Support**
***Complete Federal Tax Return & Schedules**
***Four (4) most recent pay stubs.**

Mail Completed Application to:

MHC Otsego Memorial Hospital
Attn: Financial Assistance
825 N Center Ave
Gaylord, MI 49735