Financial Assistance Application

*Please complete both sides of this form, sign and date.

Name: ________________________________ Birthdate: ___________ Social Security Number: ________________
(Patient)

Name: ________________________________ Birthdate: ___________ Social Security Number: ________________
(Guarantor/Responsible Party)

Street Address: ____________________________ City: ________________ State: ___________ Zip: ___________
(Guarantor/Responsible Party)

Telephone: __________________________ Marital Status: _____________ Number of Dependent Children: _____

MONTHLY INCOME

Patient's Employer: ______________ Self-employed [ ]

How long _____ to _____ Gross Wages $_______

Unemployed [ ] How long? _________

Social Security .... $__________

Unemployment Comp .... $ __________

Worker's Comp .... $ __________

Child Support/Alimony .... $ __________

Other Income .... $ __________

Source: ________________

TOTAL: $ __________

Spouse/Parent Employer: ______________ Self-employed [ ]

How long _____ to _____ Gross Wages $_______

Unemployed [ ] How long? _________

Social Security .... $__________

Unemployment Comp .... $ __________

Worker's Comp .... $ __________

Child Support/Alimony .... $ __________

Other Income .... $ __________

Source: __________________

TOTAL: $ __________

ASSETS

Savings: $ ______________

Institution: ____

Checking: $ ______________

Institution: ____

Other Assets: ____

Cash on Hand: $ _____________

Stocks or Bonds: $ __________

DEBTS / EXPENSES

Liabilities:	To Whom:	Monthly Payment:	Balance:
Mortgage/Rent	________________________	_______________	____________
Real Estate Prop.	________________________	_______________	____________
Bank Loan	________________________	_______________	____________
Auto Loan	________________________	_______________	____________
Credit Cards	________________________	_______________	____________
	________________________	_______________	____________
	________________________	_______________	____________
Other Expenses	________________________	_______________	____________
	________________________	_______________	____________

** PLEASE USE THIS SPACE TO DESCRIBE YOUR PERSONAL SITUATION AND YOUR REASONS FOR REQUESTING ASSISTANCE.

The following documents must be provided for guarantor of account:

- Federal Income Tax Return from 2023
- Proof of Medicaid denial for assistance (*Hospital Service Only; NOT required for RHC services*)
- Current Bank Statement (Past 90 days)
- Current Pay Check Stub(s)
- Statement of income from other sources (Social Security, Pension, Workers Compensation, etc.)

This is to advise that I have pursued all other avenues possible for payment, including private insurance, governmental and charitable agencies providing funding and relief from financial obligations; therefore, I hereby request that Aspire Rural Health System make a determination of my eligibility for their Charity Care Program. I understand that the information I submit concerning my income, family size, assets, expenses, and medical bills is subject to verification by Aspire Rural Health System. I also understand that if the information I submit is now or at any time in the future determined to be false, such a determination will result in current and/or retroactive denial of Charity Care and I will be liable for charges for services rendered. I certify that all of the information in this form is true and correct. Incomplete or fraudulent application will be denied.

____________________________________ ____________________

Patient or Responsible Party Signature Date

**Please return this application to: Aspire Rural Health System, Patient Financial Counselors,
4675 Hill Street, Cass City, MI 48726
Phone No. (989) 912-6800