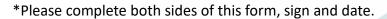


## **NHSC Financial Assistance Application**



Name: Birthdate (Patient)	e:
Name: Birthdate (Guarantor/Responsible Party)	e:
	State: Zip:
Telephone:	
MONTHLY INCOME	
Patient's Employer: Self-employed [ ]	Spouse/Parent Employer: Self-employed [ ]
How long to Gross Wages \$	How long to Gross Wages \$
Unemployed [ ] How long?	Unemployed [ ] How long?
Social Security\$	Social Security \$
Unemployment Comp \$	Unemployment Comp \$
Worker's Comp \$	Worker's Comp \$
Child Support/Alimony \$	Child Support/Alimony \$
Other Income \$	Other Income \$
Source:	Source:
TOTAL: \$	TOTAL: \$
Household Size	
Please list all family members in your household (c	laimed on previous year taxes).

## The following documents must be provided for guarantor of account:

- Most recent filed federal income tax return
- Current Pay Check Stub(s)
- Statement of income from other sources (Social Security, Pension, Workers Compensation, etc.)

I hereby request that Aspire Rural Health System make a determination of my eligibility for their Charity Care Program. I 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