



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 [] 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 (claimed on previous year taxes)

The following documents must be provided for guarantor of account:

- Most recently filed tax return
- Proof of Medicaid denial for assistance (*Hospital Service Only; NOT required for NHSC sites*)
- Current Bank Statement (Past 90 days)
- Current Paycheck Stub(s) (Past 60 days)
- Statement of income from other sources (Social Security, Pension, Workers Compensation, etc.)

Should you require assistance or have any questions regarding the completion of this application, please contact one of our financial assistance counselors at 989-912-6800

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 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