Attn: Patient Financial Counselor
1500 Sand Point Road
Munising, MI 49862
Phone: (906) 387-0639
munisingmemorial.org

FINANCIAL ASSISTANCE APPLICATION

Munising Memorial Hospital is committed to providing healthcare services to all patients who need our services.

You may be eligible for financial assistance if you are not insured or if you are underinsured. Eligibility is based upon a completed application with required proof of income documentation. Please submit your application as soon as possible after the date you receive services from the hospital or clinic. Thank You.

A copy of the sliding fee scale, based upon Department of Health and Human Services guidelines and / or a copy of the Munising Memorial Hospital Financial Assistance Policy are available upon request.

If you require assistance with your application, please contact our Patient Financial Counselor at (906) 387-0639.

	PATIENT INFORMATION	**Guarantor Information (if different than patient)**
Patient Name	___________________________	_________________________________
Relationship to Patient	___________________________	_________________________________
Date of Birth	___________________________	_________________________________
Home Phone #	___________________________	_________________________________
Work Phone #	___________________________	_________________________________
Cell Phone #	___________________________	_________________________________
Address	___________________________	_________________________________
City, State, Zip	___________________________	_________________________________

Household Information: (list all people living in household and their relationship to the applicant):

Name	Relationship
____	____
____	____
____	____
____	____
____	____
____	____
____	____

Employment Status (check one):

Employed ___ Retired ___ Disabled ___ Unemployed ___ Student ___ Dependent ___ Seasonal ___

Patient's Employer: ____

Occupation: _________________________ Employed Since: ________________

Employer's Address: ____ Phone: ________________________

Attn: Patient Financial Counselor
1500 Sand Point Road
Munising, MI 49862
Phone: (906) 387-0639
munisingmemorial.org

Monthly Income Information:

	Patient **(or Guarantor)**	**Other Household** **Member's Income**	**Total Household Income**
Employment	____________________	____________________	____________________
Pension	____________________	____________________	____________________
Social Security	____________________	____________________	____________________
Veteran's Benefits	____________________	____________________	____________________
Worker's Compensation	____________________	____________________	____________________
Interest / Dividends	____________________	____________________	____________________
Alimony or Support	____________________	____________________	____________________
Rental Property	____________________	____________________	____________________
Other (please specify)	____________________	____________________	____________________
Total Monthly Income:	____________________	____________________	____________________

Please attach a copy of the following:

_____copy of most recent paystub showing year to date income
_____copy of most recent signed federal tax return (including all pages and schedules)
_____copies of documentation, income-generating statements, or award letters, etc.

If applicable:

Medicaid application date: ________________ Reason for denial: ____________________________

I hereby certify that the above information is true and complete. Omitting information or providing fraudulent information will be cause for denial. I authorize Munising Memorial Hospital to contact the employers and institutions listed on the application to verify its accuracy, if deemed necessary. I further authorize the employer/institutions to release such information to Munising Memorial Hospital.

Patient Signature: ____ Date: __________________

Spouse or Legal Guardian: _____________________________________ Date: __________________

The patient/guarantor will be notified in writing within 10 days of the decision to approve or deny the application.

(for internal use only)

The applicant submitted all of the required information: Yes ____ No ____

The Sliding Fee Scale Program is: Approved _____ % _____ Denied _____

If denied, reason for denial: ____

Date applicant was provided with a copy of determination: ____________________________________

Signature of person making eligibility determination: ________________________________ Date: ____________________