

**Re: Application for Assistance**

Thank you for expressing an interest in our Financial Assistance Program. Depending on your family income, you may be eligible for a discount up to 100% of the amount owed on your hospital bill. In order for us to determine if you qualify for a discount, or to determine a monthly payment plan if you do not qualify for a full discount, please complete the enclosed **Application for Assistance** and provide the following information:

- ∞ Most current pay stub showing year-to-date earnings for all working members of the household.
- ∞ Support for all other income, including, but not limited to, SSI or other government income, retirement, child support, alimony, food stamps.
- ∞ Most recent income tax return IF self-employed or clergy.
- ∞ Most recent Bank statement for all cash accounts, investments and IRA's representing at least 30 days activity.

If you do not have any income, please provide an explanation as to how you support yourself and your family.

Failure to provide complete information may result in delay or denial of your application.

Please return your completed application and the information above to:

Oaklawn Patient Financial Services  
200 North Madison  
Marshall, MI 49068

You will be notified of the determination of eligibility within 30 days of receipt of your application.

A copy of the hospital's financial assistance policy can be obtained from the hospital's website [www.oaklawnhospital.org](http://www.oaklawnhospital.org) or by calling PFS and requesting a copy be mailed to you.

If you have any questions concerning completion of the application or the required information, please do not hesitate to contact us. Patient Financial Services can be reached by calling 269-789-7000. Our hours are Monday through Friday from 7:30 am to 5:00 pm.

Sincerely,

Oaklawn Hospital  
Patient Financial Services

**APPLICATION FOR ASSISTANCE/MONTHLY PAYMENT PLAN**

Patient or responsible party name \_\_\_\_\_

Date of birth \_\_\_\_\_ Best phone number(s) to reach you \_\_\_\_\_

Best time of day to reach you : \_\_\_\_\_

List the names of all patients this application applies to: \_\_\_\_\_

\_\_\_\_\_

Please provide information below for all individuals living in the household (including your spouse or significant other) AND all persons you or your spouse are financially responsible for (continue on back of form if needed).

Name tax return (Y/N)	Relationship	Age	Claim on income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total number of dependents claimed on the responsible party's income tax return \_\_\_\_\_

Other than the responsible party listed above, is there anyone else financially responsible for or required to carry health insurance for the patient? If yes, please provide their name, address and telephone number on the back of this form. Yes \_\_\_\_\_ No \_\_\_\_\_

**Responsible Party Employment Information**

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Health Insurance offered Y/N \_\_\_\_\_

How long employed \_\_\_\_\_ Hours/week \_\_\_\_\_ Gross pay/week \_\_\_\_\_

**Spouse or Other Household Employment Information**

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_ Health Insurance offered Y/N \_\_\_\_\_

How long employed \_\_\_\_\_ Hours/week \_\_\_\_\_ Gross pay/week \_\_\_\_\_

*Include income for all working members of household. Use back of form if necessary.!*

**Other Source(s) of Income**

Other sources of income include, but are not limited to, **unemployment benefits, social security payments, investment income, rental income, child support, food stamps, or any other income received.**

Source \_\_\_\_\_ Monthly Amount \$ \_\_\_\_\_  
Source \_\_\_\_\_ Monthly Amount \$ \_\_\_\_\_  
Source \_\_\_\_\_ Monthly Amount \$ \_\_\_\_\_

**Banking & Asset Information**

Bank/Financial Institution \_\_\_\_\_

City \_\_\_\_\_ Acct # \_\_\_\_\_ Balance \_\_\_\_\_

Bank/Financial Institution \_\_\_\_\_

City \_\_\_\_\_ Acct # \_\_\_\_\_ Balance \_\_\_\_\_

Cash value of stocks/bonds \_\_\_\_\_ Money Market accounts \_\_\_\_\_ IRA \_\_\_\_\_

Other than your primary residence and primary vehicles, please indicate any other assets you own not previously listed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Indicate on the back of this form any additional information you feel will be helpful to us in determining your eligibility for assistance or a payment plan.**

**Authorization** (Your signature is required before we will process your application)

I do hereby believe this to be a true and complete representation of my income and financial situation as of the date indicated below. I understand that the Hospital may be requesting a credit report to verify the above information.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

If you need help completing this form, or if you have any questions, please contact Patient Financial Services by calling 269.789.7000. Office hours are Monday through Friday, 7:30am to 5:00pm.