Financial Assistance Application

Oaklawn Medical Group Attn: PASC
200 N Madison, Marshall, MI 49068

Dear Patient/Applicant:

Thank you for your interest in Oaklawn Medical Group Financial Assistance. Enclosed is the application for financial assistance. This program covers emergent and medically necessary services provided at the locations listed in Appendix A of this application. Depending upon your household income you may be eligible for discounts up to 100% of your medical bill. To determine your eligibility please complete the enclosed application and return the required documentation listed below within 15 days of receipt of this application to the address above or email PASCFAX@oaklawnhospital.com.

REQUIRED DOCUMENTATION

- ☐ Completed Application
- ☐ Proof of income:
  - Last two pay stubs showing YTD gross income*
  - If self-employed, prior year's personal income tax return and tax return for the business including all schedules.
  - Social Security and/or Pension Retirement award letter.
  - Copy of receipt of unemployment benefits.
  - If child support is received, a copy of most recent court documentation or printed confirmation from Friend of the Court.
  - All other income documentation (pension, VA Benefits, worker's compensation, etc.).

    **If patient/applicant reports zero income and/or receives assistance from or live in a home with family or friends, the attached Letter of Support must be completed.*
- ☐ Copies of medical insurance cards if patient/applicant has coverage.
- ☐ Copy of Michigan driver's license or Michigan state identification card.

Failure to complete the required documentation may result in delay or denial of your application. Oaklawn Medical Group reserves the right to request additional documentation that may assist in the final determination of eligibility for assistance.

For details or assistance, please contact the Patient Accounts Service Center (PASC) at 269-789-7000, Monday through Thursday 8:00 am to 5:00 pm and Friday 8:00 am to 4:00 pm.

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Patient/Applicant Information

Please print and complete all fields.

Date: _____

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Is patient a legal residence of the United States: ☐ Yes ☐ No

Name of Employer: _____

Did you have insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ☐ Yes ☐ No

Name of Insurance: _____ Effective Date of Insurance: _____

Subscriber Name: _____ Subscriber ID: _____ Group Number: _____

Spouse Information

Spouse Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Date of Birth: _____

Name of Employer: _____

Name of Insurance: _____ Effective Date of Insurance: _____

Subscriber Name: _____ Subscriber ID: _____ Group Number: _____

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Household Information

Please provide the information for all dependents and/or members of the household. Eligibility for assistance will be applied to all family members listed below.

Family Member Name(s)	Date of Birth	Relationship to responsible party

Income Information

Provide income information and support for all members of the household.

Income Source	Current Monthly Gross Income or Hourly Rate Patient	Current Monthly Gross Income or Hourly Rate Spouse/Other	Total Monthly Household Income
Wages	$	$	$
Self-Employment	$	$	$
Child Support or Alimony	$	$	$
Social Security/Pension	$	$	$
Unemployment or Workers' Comp	$	$	$
Veterans Benefit	$	$	$
Other Income	$	$	$
TOTAL	$	$	$

I hereby certify that the above information is true and complete to the best of my knowledge. I understand that Oaklawn Medical Group reserves the right to request any additional information needed to determine eligibility. I also understand that this application may be denied if the requested documentation/information is not provided upon request.

Signature of Responsible Party: _____ Date: _____

Signature of Spouse/Other: _____ Date: _____

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Appendix A

Provider	Address	Phone #
Oaklawn Medical Group Marshall Internal & Family Medicine	720 Old US 27 North Marshall, MI	(269) 781-6600
Oaklawn Medical Group Obstetrics & Gynecology	215 E Mansion St, Ste 3D Marshall, MI	(269) 558-0702
Oaklawn Express Care Albion Primary Care	302 N Monroe St, Suite A Albion, MI	(517) 629-2134
Oaklawn Medical Group Albion Express Care	302 N Monroe St, Suite B Albion, MI	(517) 654-1020
Oaklawn Medical Group Olivet Primary Care	202 N Main St Olivet, MI	(269) 749-2131
Oaklawn Medical Group Marshall Express Care	1174 W Michigan Ave, Suite B Marshall, MI	(269) 789-4390
Oaklawn Medical Group Michigan Avenue Primary Care	1174 W Michigan Ave, Suite A Marshall, MI	(269) 558-0700
Oaklawn Medical Group Coldwater Primary Care	375 N Willowbrook Rd Coldwater, MI	(517) 924-1605
Oaklawn Medical Group Beadle Lake Primary Care	14231 Beadle Lake Rd Battle Creek, MI	(269) 962-0441
Oaklawn Medical Group Marshall Primary Care	215 E Mansion St, Suite 1E Marshall, MI	(269) 781-3938

Oaklawn

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Appendix B

For 2025, the AGB (Amounts Generally Billed) is:

Inpatient 26.78%
Outpatient 23.95%

Family Size	2025 Poverty Level Annual Income	200% of Poverty Level Full Adjustment (100%) if at or below.	250% of Poverty Level 75% Adjustment if at or below	300% of Poverty Level 50% Adjustment if at or below
1	$15,650	$31,300	$39,125	$46,950
2	$21,150	$42,300	$52,875	$63,450
3	$26,650	$53,300	$66,625	$79,950
4	$32,150	$64,300	$80,375	$96,450
5	$37,650	$75,300	$94,125	$112,950
6	$43,150	$86,300	$107,875	$129,450
7	$48,650	$97,300	$121,625	$145,950
8	$54,150	$108,300	$135,375	$162,450

For Families/households with more than 8 persons, add $5,500 for each additional person

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Letter of Support

Patient Name _____

Patient Date of Birth _____

Supporter's Name _____

Supporter's Address _____

Relationship to patient/applicant _____

To Oaklawn Medical Group:

This letter is to confirm that (patient's name) _____

receives little to no income and I am assisting with the following living expenses:

☐Housing (assist with rent/monthly mortgage or patient lives in my household rent free)

☐Utilities

☐Groceries

☐Other _____

By signing this Letter of Support, I agree that the above information in true to the best of my knowledge and my signature does not make me financially responsible for the patient/applicant's medical charges.

Signature _____

Date _____