Financial Assistance Application

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

Dear Patient/Applicant:

Thank you for your interest in Oaklawn Hospital Financial Assistance. Enclosed is the application for financial assistance. This program covers emergent and medically necessary services provided at Oaklawn Hospital & Oaklawn Medical Group. Depending upon your household income you may be eligible for discounts up to 100% of your hospital 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.*
- ☐ Last two months of most recent bank statements (checking/savings/money market accounts).
- ☐ A copy of the Medicaid Denial letter if the patient is uninsured.
- ☐ 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 Hospital 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	$	$	$

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Assets

Please list all assets that apply for the responsible party, spouse, and all other family members.

Asset Type	Current Balance for responsible party	Current Balance for Spouse/Other
Bank Account – Checking	$	$
Bank Account – Savings	$	$
Bank Account – Money Market	$	$
TOTAL	$	$

I hereby certify that the above information is true and complete to the best of my knowledge. I understand that Oaklawn Hospital 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

For 2026, the AGB (Amounts Generally Billed) is:

Inpatient 28.01%
Outpatient 23.94%

Family Size	2026 Poverty Level Annual Income	250% of Poverty Level Full Adjustment (100%) if at or below.	300% of Poverty Level 75% Adjustment if at or below	350% of Poverty Level 50% Adjustment if at or below
1	$15,960	$39,900	$47,880	$55,860
2	$21,640	$54,100	$64,920	$75,740
3	$27,320	$68,300	$81,960	$95,620
4	$33,000	$82,500	$99,000	$115,500
5	$38,680	$96,700	$116,040	$135,380
6	$44,360	$110,900	$133,080	$155,260
7	$55,040	$137,600	$165,120	$192,640
8	$55,720	$111,440	$167,160	$195,020

For families/households with more than 8 persons, add $5,680 for each additional person

Eligibility for 50/50 Plan

Income is less than % of poverty level based upon household size…	Balance is at least…
200% of PL	$2,000
201% to 250%	$3,000
251% to 300%	$4,000
301% to 350%	$6,000
351% to 400%	$8,000
401% to 450%	$10,000
451% to 500%	$12,000
501% to 550%	$15,000
551% to 600%	$18,000
More than 600%	$22,000

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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 Hospital:

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 _____