4675 HILL STREET
CASS CITY, MI 48726

Hills & Dales HEALTHCARE

(989) 872-2121
WWW.HDHLTH.ORG

Financial Assistance Application

Thank you for choosing Hills & Dales Healthcare for your healthcare needs. Hills & Dales Healthcare is proud to provide quality and affordable healthcare to the community. We are here to assist those who are in need of financial assistance and to help those who may have difficulty paying their medical bills.

Enclosed is our Plain Language Summary of our Financial Assistance Policy. This will explain the process and eligibility requirements for applying for financial assistance application. To view the full policy please visit www.hdhlth.org and click on billing/financial assistance or contact one of our collection specialists at 989-912-6800 for a paper copy.

To apply for Financial Assistance please fill out the attached application and submit it to Hills & Dales Healthcare in person or by mail within 240 days following the date the first billing statement is sent to the patient/guarantor. Financial assistance approvals will be effective for a period of 90 days and include subsequent emergent or medically necessary care. A change in financial situation or the addition of third-party eligibility may alter the approval period and require further review. Financial assistance approvals will not include those accounts currently at a collection agency unless it has been 240 days or less since you received your first patient statement.

Applications can also be uploaded along with required documents directly to MyChart.

The patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist Hills & Dales Healthcare in determining whether the patient is eligible for financial assistance.

The information requested on this form is requested so that Hills & Dales Healthcare can give full consideration to a request for charity

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care. The information will be kept confidential and will not be used for any other purpose.

Required Documents:

- ☐ Copy of most recent pay stub
- ☐ Current Federal Income Tax Return
- ☐ Copy of most recent statement/check voucher for all other income benefits including:
  - Social Security
  - VA
  - Unemployment/Severance Pay
  - Pension/Retirement
  - Alimony and Child Support
  - Work Comp
  - Trust
  - Rental
  - Interest/Dividend
  - Disability
  - Other
- ☐ Most recent checking bank statement - to be used as income verification only.
- ☐ Balance will not impact financial assistance write-off amount.
- ☐ Forms approving or denying Unemployment.

General Information

Patient's Name: _____
Account/Guarantor # _____
Date of Service: _____
Address: _____
Telephone #_____
Name of Responsible Party (Guarantor): _____
Relationship to Patient: _____
Employer: _____
Address: _____
If Unemployed, how long? _____
Spouse's Employer: _____
Address: _____
If Unemployed, how long? _____

List All Family Members in Your Household

_____
_____ _____ _____
_____ _____ _____
_____ _____ _____

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Monthly Household Income & Sources

	Patient	Spouse	Responsible Party	Other(s)
Monthly Salary (gross)				
Unemployment/work comp				
Public Assistance Benefits				
Social Security Benefits				
Child Support				
Retirement/Pension				
Other (Alimony, etc.)				

(Office Use Only) Annual Total$ _____

Monthly Household Expenses

Name of Mortgage Holder: _____
Rent or Own _____

	Monthly Payment	Outstanding Balance
Mortgage/Rent		
Home Insurance		
Property Taxes		
Auto Payment		
Gas/Transportation		
Food		
Telephone/Cell Phone		
Utilities		
Health Insurance		
Life Insurance		
Medical Bills		
Child Care		
Other:		
Other:		
Other:		
Other:		

(Office Use Only) Annual Total$ _____

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Monthly Medical Supplies/Pharmacy(Medications)

Supplies/Pharmacy	Monthly Expenses:

(Office Use Only) Annual Total $ _____

Did you file an income tax return last year?_____
If yes, please provide a copy.
If no, please explain the reason you did not file _____
_____

Any incomplete applications will be denied.

I certify that the information submitted herein is true and accurate to the best of my knowledge. I understand that this application is made so that Hills & Dales Healthcare can determine my eligibility for a discount based on the financial assistance sliding scale program criteria. If any information I have given proves to be untrue, I understand that the hospital or other operating entity may re-evaluate my financial status and take whatever action is appropriate.

Applicants Signature: _____
Date of Request: _____

Office Use Only

Date Received: _____
Financial Assistance Counselor name: _____
Special Notes:
_____
_____