Sparrow Health System Financial Assistance Application Account #'s: _____
Community Financial Aid Information Request (A-1) _____
_____
_____

Patient Name: _____

Name of Resp. Party: _____

Relationship to Patient: _____

Address: _____

City, State, ZIP: _____

Phone #: _____

Social Security #: _____

# of Dependents/Ages: _____

Employer: _____

Employment Status: (Check all that apply)

Actively Employed	_____
Unemployed	_____
Retired	_____
Disabled	_____
Student	_____

Pay Frequency: Weekly__ Bi-weekly__ Monthly__

Income Information-Monthly

Source	Amount
Gross Pay	$_____
Social Security	$_____
Pension	$_____
Unemployment	$_____
State/Federal Assistance	$_____
Contributions from Others	$_____
Student Loans/Grants	$_____
Total Income	**$_____**

Please provide proof of all household income including:

1. Two current paystubs
2. Most recent federal tax return (all schedules)
3. Other supporting documentation
4. Letter explaining how basic needs are met if zero income is reported.

I state that the above information is correct to the best of my knowledge. I permit Sparrow Health System to check any information to make sure it is complete and accurate. I approve the release of such information to Sparrow Health System, which will allow Sparrow to obtain a personal credit report for either the patient or person guaranteeing payment of the bill.

I understand that Sparrow Health System may provide me with discounted or free care. I further understand that if I choose to accept this care and later file a lawsuit (including any administrative proceeding or, arbitration) to recover money from Sparrow Health System or any of its member hospitals for any reason related to this care, any money I recover will be reduced by the amount of free care I received.

_____ _____
Patient or Responsible Party Signature Date

For Hospital Use Only

Approved ___ Denied ___

_____
Approval Signature Date

_____
Reason for Denial

Calculated Income $_____

Approval Level 1 2 3 4

Total Acct. Balances $_____

Discount Amount $_____

Patient Balance $_____