Sparrow Health System Financial Assistance Application

A Patient Information: *Please complete this section about the patient receiving care*

Patient Name: _____ DOB: _____

Social Security Number: _____ MRN: _____ Guarantor ID: _____

B Responsible Party (Guarantor): *Please complete this section about the person paying the medical bill*

Responsible Party Name: _____

Relationship to Patient: _____

Street Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____ County: _____

Employer: _____ □ Full-time □ Part-time

C Health Insurance Eligibility Verification

1. Have you applied or been denied for Medicare or Medicaid		3. Does your employer or spouse's employer offer group health insurance	□ No □ Yes
1A. Medicare Part A	□ No □ Yes		
1B. Medicare Part B	□ No □ Yes	4A. Did you have coverage in the	
1C. Medicare Part C	□ No □ Yes	last 3 to 6 months through your	□ No □ Yes
1D. Medicaid	□ No □ Yes	employer?	
If you were denied for Medicaid, was the denial within the last 90 days?	□ No □ Yes	**If yes**, is COBRA available?	□ No □ Yes
2. Are you applying for financial assistance for services related to:		5. Do you have any other health insurance?	□ No □ Yes
		If yes, please provide the insurance information:	
2A. Motor Vehicle Accident (MVA)	□ No □ Yes		
2B. Crime Victim	□ No □ Yes	6. Are you a permanent resident who lives within the Sparrow Health System service area?	□ No □ Yes
2C. Workers Compensation	□ No □ Yes		
2D. Other Injury (e.g. Slip and Fall)	□ No □ Yes		

D Household Members & Household Employment Income

How many people are in your household?: _____

Please list any household member who earns an income (attach another sheet if needed):

Household Member Name	Relationship to Applicant	Monthly Gross Income (before deduction)
		$
		$
		$
	Total Monthly Gross Income	$

E Household Other Income (Non-Employment)

Other Income Sources	Amount per Month
Child Support/ Alimony	$
Foster Care, Township Trustee, Church Income, etc.	$
Pension, Social Security, Social Security Disability	$
Rental Property	$
Annuities, Interest, Retirement Distribution	$
Unemployment or Worker's Compensation	$
Other (*Please specify)*	$
Total Other Income Sources	$

F Household Assets

Type of Asset	Total
Cash	$
Savings Account	$
Checking Account	$
Stocks	$
Bonds	$
Savings Bonds	$
Certificates of Deposit (CDs)	$
Money Market Accounts	$
Mutual Funds	$
Trusts	$
Other (*Please specify)*	$
Total Other Income Sources	$

G Monthly Household Expenses

Other Income Sources	Amount per Month
Rent	$
Mortgage	$
Child Support	$
Groceries	$
Vehicle Payment	$
General Bills	$
Total Other Income Sources	$

H Authorization

I hereby authorize the release of the information contained in this application to Sparrow Health System for the determination of my eligibility status for financial assistance in accordance with Sparrow policies and procedures. I authorize Sparrow to verify this information as necessary, which may include but is not limited to, obtaining a credit bureau report, verifying employment and/or income, and obtaining appropriate supporting documents. All information and income documentation provided by me in this application is true, accurate and complete as shown. If it is determined at any time the information, I provided was false or inaccurate, all financial assistance will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. I also agree to accept payment responsibility for any amount due after any partial financial assistance discounts.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____