IHA FINANCIAL ASSISTANCE APPLICATION

INSTRUCTIONS FOR COMPLETING THIS FORM

In order for a patient to be eligible for special financial consideration, this form must be completed with the requested documentation attached. The information provided will be reviewed and proper determination will be made in a timely manner. Please provide the following documentation to our Patient Financial Services Manager.

- **This form, completed and signed**
- **Copy of signed Federal Income Tax Return for previous year**
- **Copies of payroll check stubs for the previous 2 months, or other income vouchers**
- **A financial statement may be required if you are self-employed**

Account Number _____ Balance _____

Patient Name _____ Date of Birth_____

Patient Name _____ Date of Birth_____

Patient Name _____ Date of Birth_____

Patient Name _____ Date of Birth_____

Address _____ Telephone _____

_____ Social Security # _____

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE INDIVIDUAL RESPONSIBLE FOR PAYMENT

Name _____ Date of Birth _____

Address (if different) _____

Telephone _____Social Security Number _____

PLEASE PROVIDE THE FOLLOWING FOR ALL HOUSEHOLD MEMBERS (Attach additional sheet if necessary)

Name	Date of Birth	Relationship to Patient	Social Security #

Do you have medical insurance? ☐ No ☐ Yes Do you have Medicaid? ☐ No ☐ Yes

Have you applied for Medicaid and been found to be ineligible? Yes No (circle one) Date: _____

INCOME FROM EMPLOYMENT

Person Employed	Employer	**Gross Pay**	**Per**
			☐ **Wk** ☐ 2 **Wks** ☐ **Mo**
			☐ **Wk** ☐ 2 **Wks** ☐ **Mo**
			☐ **Wk** ☐ 2 **Wks** ☐ **Mo**

HOUSEHOLD INCOME FROM OTHER SOURCES **AMOUNT PER MONTH**

Child Support / Alimony Received ..... $ _____
Food Stamps / Foster Care / Church ..... $ _____
Income / Assistance / Lunch Programs, etc. ..... $ _____
Pension / Social Security / Social Security Disability ..... $ _____
Rental Property ..... $ _____
Stocks, Bonds, Annuities, Interest ..... $ _____
Unemployment or Worker's Compensation ..... $ _____

TOTAL MONTHLY GROSS INCOME: $_____

ASSETS

Cash on Hand ..... $ _____
Checking Account Balance Bank _____ $ _____
Bank _____ $ _____
Health Savings Account ..... $ _____
401(K), 403(b) or Other Retirement Savings ..... $ _____
Investments or Other Securities ..... $ _____
Life Insurance Policy Cash Value ..... $ _____
Medical Savings Account ..... $ _____
Savings Account Balance Bank _____ $ _____
Bank _____ $ _____
Stocks, Bonds, IRA, Certificates of Deposit Type/Bank _____ $ _____
Real Estate (Primary Residence) _____ Value ➔$ _____
Other Real Estate: Location _____ Value ➔$ _____
Vehicles:Year/Make/Model _____ Value ➔$ _____
Year/Make/Model _____ Value ➔$ _____

TOTAL ASSETS: $ _____

HOUSEHOLD LIABILITIES/EXPENSES

Rent/Mortgage per Month(Mortgage Balance $_____)$ _____
Grocery Expense per Month ..... $ _____
Child Care / Child Support / Alimony Paid per Month ..... $ _____
Utilities per Month:Gas $_____ Electric $_____ Water/Sewer $_____ $_____
Trash Service Expense per Month ..... $ _____
Telephone ..... Cell $_____ Home $_____ $ _____
Medication Expenses per Month ..... $ _____
Medical Needs per Month (including charges, monthly obligations to doctors or other hospitals) $ _____
Insurance Premiums per Month: Life $_____ Auto $_____ Home $_____ Health $_____ $_____
Vehicle Loan Payments per Month(Balance Owed) _____ $_____
Transportation per Month ..... $_____
Loan Payments per Month _____ Total Loan Balance $_____ $_____
Credit Card Payments per Month _____ Total Credit Card Balance $_____ $ _____
Cable Television / Satellite per Month ..... $ _____
Internet Service Provider/DSL per Month ..... $ _____

TOTAL MONTHLY PAYMENTS $ _____

OTHER CIRCUMSTANCES WE SHOULD CONSIDER IN ASSISTING YOU:

I hereby state that the information I have provided is true and complete. I authorize **IHA** to verify this information, including requesting a credit bureau report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration, I will be liable for payment of any and all charges incurred for the services rendered, and/or may be dismissed from the practice.

X _____ **Date:** _____
Responsible Party Signature

Please return completed form and proper documentation to:

IHA Business Services Department CONFIDENTIAL
Attention: Patient Financial Services Manager
P O Box 0446, Ann Arbor, MI. 48106-0446