



Patient Financial Assistance Programs
Henry Ford Hospital & Health Network

Dear Henry Ford patient,

Thank you for choosing Henry Ford Health System for your healthcare needs. We recognize our role in providing access to medically necessary healthcare services for all persons regardless of their ability to pay. Patient Financial Assistance Programs at Henry Ford Health System are available and you may be eligible for help with the self-pay portion of your bill. To see if you qualify, please follow the steps below:

1. If you are uninsured, please contact your local Department of Human Services office to apply for Medicaid. You must apply for Medicaid to be considered for any discounts beyond the Standard Uninsured Discount. Contact one of the offices below to find the closest location:

Lapeer County: (810) 667-0800

Monroe County: (734) 243-7200

St. Clair County: (810) 966-2000

Macomb County: (586) 254-1500

Oakland County: (248) 975-4800

Washtenaw County: (734) 481-2000

Wayne County: (313) 396-0200

2. Complete and sign the attached application within 10 days. In addition to the application, you need to provide copies of the following:

- Proof of Income – provide one of the following:

- 3 most recent pay stubs
- 3 months of bank statements
- Most recent federal tax return
- Official statement of disability or unemployment income

*If you do not have any of the requested types of Proof of Income; please provide a letter of support demonstrating how you are paying for your living expenses. This letter should be from a family member, friend or organization that is supporting your living needs.

- Copies of medical insurance cards (front and back) if you have coverage, including Medicaid

- If you applied and were denied Medicaid, a copy of the denial letter

3. Return application and all requested documents to:

Patient Financial Assistance Planning Office

Henry Ford Hospital

2799 West Grand Blvd

K-1, West 107 Clinic Building

Detroit, MI 48202

FAX: (313) 916-4501

Once we receive your application we will determine what programs you are eligible for and send you a letter regarding our decision. If you need help completing the application or if you have questions, call (313) 916-3827.

Applications are reviewed without discrimination including ability to pay for services. All financial and personal information will be used only in the determination of eligibility for financial support. We are committed to maintaining and protecting your privacy regarding this information. Applications will be destroyed one year after the review date.



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We can only consider financial support based upon a completed APPLICATION with PROOF OF INCOME. If you have no form of income, please include a letter from the person/organization that is assisting you with living expenses (housing, food, utilities, etc.). PLEASE COMPLETE THIS APPLICATION and return it with PROOF OF INCOME within 10 days to: Patient Financial Assistance Planning Office, Henry Ford Hospital, 2799 W. Grand Blvd., K1-W107 Clinic Bldg, Detroit, MI 48202; Fax: (313) 916-4501

Applicant's Name: _____ Date of Birth: _____
Address: _____ Telephone: _____
Social Security Number: _____
Account/Medical Record Number: _____ Drivers' License #: _____

What HFHS site(s) have you received services?: [] Henry Ford Hospital; [] Henry Ford Macomb Hospital;
[] Henry Ford Macomb-Warren Campus; [] Henry Ford Wyandotte Hospital; [] Henry Ford Cottage Hospital;
[] Henry Ford Medical Centers; [] Henry Ford at Home; [] Greenfield Health Systems (Dialysis centers);
[] Josephine Ford Cancer Center - Downriver; [] Other: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS (Attach additional sheet if necessary)

Table with 4 columns: Name, Date of Birth, Relationship to Applicant, Social Security Number

Do you have medical insurance*? No Yes* If yes, name of carrier: _____
Deductible Amount: _____ Copay/Coinsurance: _____

Do you have MEDICAID? No Yes* Do you have MEDICARE? No Yes*
If denied Medicaid, please include copy of denial letter. *Please provide a photocopy of insurance card.

HOUSEHOLD INCOME FROM EMPLOYMENT (Attach additional sheet if necessary)

Table with 4 columns: Person employed, Relationship to applicant, Employer Name, Gross Monthly Pay (before deductions)

HOUSEHOLD INCOME FROM OTHER SOURCES AMOUNT PER MONTH
Child Support \$ _____
Food Stamps/foster care/township trustee/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

Table listing assets: Cash on hand, Checking account, Savings account, Health/medical savings account, Stocks, bonds, IRA, certificates of deposit type/bank, Real estate (excluding primary residence), Vehicle(s): year/make/model, TOTAL ASSETS: \$ _____



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Table with 2 columns: HOUSEHOLD LIABILITIES & MONTHLY EXPENSES and AMOUNT PER MONTH. Rows include Rent/mortgage, Grocery expense, Child care, Utilities, Telephone, Prescription expense, Insurance premiums, Car loan payments, Transportation, Loan payments, Credit card payments, Cable Television/Satellite, and Internet Service Provider/DSL. Total Expenses line at the bottom.

Other information that we should know to assist in reviewing your application (Are you homeless?, etc.):

PROOF OF INCOME: You must attach one of the following to verify your income: 3 most recent pay stubs; 3 months of bank statements; most recent federal tax return, official statement of disability or unemployment income. If you do not have any of these, please submit a letter of support from a family member of friend who is supporting your living expenses.

I hereby authorize the release of the information contained in this application to Henry Ford Health System (HFHS) for the determination of my eligibility status for financial assistance in accordance with HFHS policies and procedures. I authorize HFHS to verify this information as necessary, which may include but is not limited to, obtaining a credit bureau report, employment and/or income verification, and 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 are applied.

Applicant's Signature: _____ Date: _____

OFFICE USE ONLY
Approved for Std. Uninsured Discount, Need-Based, Medical Subsidy or Underinsured Discount (please circle):
No Yes; % _____
Received Date: _____ Review Date: _____ Coverage Terms: _____
Denial Reason: _____
Reviewer Signature: _____ Financial Support Adjustment: \$ _____
Account Number(s) Updated: _____