HENRY FORD HEALTH SYSTEM
HENRY FORD MACOMB HOSPITALS



Patient Financial Assistance Programs
Henry Ford Macomb Hospitals

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
   Macomb County: (586) 254-1500
   Monroe County: (734) 243-7200
   Oakland County: (248) 975-4800
   St. Clair County: (810) 966-2000
   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:

Henry Ford Macomb Hospitals
Attn: Financial Support
215 North Ave.
Mt. Clemens, MI 48043
FAX: (586) 466-9933

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 (866) 785-2455.

*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: **Henry Ford Macomb Hospitals, Attn: Financial Support, 215 North Ave., Mt. Clemens, MI 48043 Phone: (866) 785-2455 Fax: (586) 466-9933**

**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)**

| 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)

| 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**

Cash on hand……………………………………………………………… $ ____________________
Checking account……………………..……….. Bank______________________ ____________________
Savings account……………………..………… Bank______________________ ____________________
Health/medical savings account…………………………..…………………………... ____________________
Stocks, bonds, IRA, certificates of deposit type/bank______________________ ____________________
Real estate (excluding primary residence)……………………………...VALUE ____________________
Vehicle(s): year/make/model______________________________VALUE ____________________

**TOTAL ASSETS: $** ____________________

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MACOMB HOSPITALS



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**HOUSEHOLD LIABILITIES & MONTHLY EXPENSES** **AMOUNT PER MONTH**

Rent/mortgage……………………mortgage balance $____________ $____________________
Grocery expense………………………………………………………... ____________________
Child care/child support/alimony……………………………………….. ____________________
Utilities…….. Gas $_______ Electric $________ Water/Sewer _______ ____________________
Telephone…………………………. Cell $ _______ Home $ ________ ____________________
Prescription expense……………………………………………………. ____________________
Insurance premiums: Life $____Auto $_____Home $_____Health $____ ____________________
Car loan payments……………………balance owed $______________ ____________________
Transportation…………………………………………………………… ____________________
Loan payments…………………………balance owed $______________ ____________________
Credit card payments…………………...total balance owed $__________ ____________________
Cable Television/Satellite………………………………………………. ____________________
Internet Service Provider/DSL…………………………………………. ____________________
**TOTAL EXPENSES:** $____________________

**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:_______________________________________________________