



- McLaren Regional Medical Center
- Ingham Regional Medical Center
- Bay Regional Medical Center
- Lapeer Regional Medical Center
- McLaren Medical Group
- McLaren Visiting Nurse & Hospice
- Mt Clemens Regional Medical Center
- POH Regional Medical Center

## Request For Financial Assistance

Total of Balance(s) Due \_\_\_\_\_ Acct. #'s \_\_\_\_\_

Patient Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Name Responsible Party (Guarantor) \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Please Check One:     Actively Employed         Self-Employed         Unemployed         Retired         Disabled

If Employed – are you working:    Full-time    Part-time    Casual    Average # hrs/Week \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_

Spouse Employer \_\_\_\_\_

Please Check One:     Actively Employed         Self-Employed         Unemployed         Retired         Disabled

If Employed – are you working:    Full-time    Part-time    Casual    Average # hrs/Week \_\_\_\_\_

Name and Age of Dependents (include self & spouse) \_\_\_\_\_

### SAVINGS (CD, Money Market, IRA), Checking and Credit Union Accounts

Bank Name	City	Type of Account	Balance

Do you own your home?    Yes    No    If Yes, list below.

Do you own any other property?   Vehicles, RV's, other real estate    Yes    No   If Yes, list below.

### ASSETS

Asset – Home, Vehicle, etc.	Market Value	Loan Amount Outstanding

**HOUSEHOLD MONTHLY INCOME AND EXPENSES**

Income Item	Amount (Monthly)	Expense Item	Amount (Monthly)
Total Household Gross Pay		Rent/Mortgage	
Social Security Income		Property Taxes	
Interest Income		Automobile	
Rental Income		Insurance: Homeowners	
Alimony		Insurance: Automobile	
Child Support		Insurance: Health	
Pension		Insurance: Life	
General Assistance		Utilities	
Unemployment		Groceries	
State/Federal Assistance		Gasoline	
Contributions from Others		Medical	
Land Contract Income		Alimony/Child Support	
Worker's Comp		Other	
Military Family Allotments		Other	
Other (please specify)		Other	

**INSTALLMENT LOANS AND CREDIT CARDS**

Creditor	Balance Owed	Monthly Payment

Total Income	Total Expenses

Please attach any further details regarding your Income and Expenses that may be pertinent to your application.

I hereby affirm that the above information is correct to the best of my knowledge. I authorize McLaren Health Care Corporation (MHCC) and its subsidiaries to verify any information for completeness and accuracy. I further authorize such information to be available for release to MHCC and its affiliates. I understand that as a charitable organization, MHCC may provide me with discounted or free care. I further understand that a personal credit report may be obtained in the decision making process.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Date

Approvals are valid for six months, upon which updated information will be required for any future services. Agreeable payment arrangements must be made for any remaining balance and can be re-evaluated at MHCC's discretion.

APPROVED  DENIED

\_\_\_\_\_  
AUTHORIZED SIGNATURE

\_\_\_\_\_  
DATE

REASON FOR DENIAL: