Spectrum Health Lakeland

CONFIDENTIAL FINANCIAL ASSISTANCE APPLICATION - LAKELAND

Instructions: Complete application, return within 10 days, and attach copies of:

- ☐ Most recent tax return
- ☐ Three months complete bank statements
- ☐ Medicaid determination/denial, if applied
- ☐ Current Statements for all investments
- ☐ Three months proof of income (pay stubs, etc.)
- ☐ If no income, a letter from party providing support

Patient Information (Print)		
Name (Last, First, Middle Initial)		Date of Birth
Address		
Primary Phone ( )	Secondary Phone ( )	Social Security/EIN
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other _____		Are you a documented resident of the United States? ☐ Yes ☐ No
Do you file a Federal Tax Return? ☐ Yes ☐ No If No, why? _____		Who is the primary filer? ☐ Self ☐ Spouse ☐ Other _____
Employer		Did you have health insurance or any other coverage at the time of your service? ☐ Yes ☐ No

Household Information (List all people who live in your household)			
Name of Household Member	**Date of Birth**	**Relationship**	**Is this person listed on your Federal Tax Return?**
1.			☐ Yes ☐ No
2.			☐ Yes ☐ No
3.			☐ Yes ☐ No
4.			☐ Yes ☐ No
5.			☐ Yes ☐ No
Any additional household members can be submitted on additional paper.			

Expenses (List monthly expenses for all household members) This section is NOT REQUIRED for NHSC or MSLRP clinics		
House Payment/Rent/Lot Rent	Property Taxes (year)	House/Rental Insurance
Car Payment	Car Insurance	Fuel (vehicle)
Phone	General Utilities	Groceries
Childcare/Child Support	Tuition	Other
Health Insurance/Expenses	Life Insurance	Other

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Income (List income for all household members)					
Monthly Income Source	**Who receives this?**	**Gross Monthly Income**	**Monthly Income Source**	**Who receives this?**	**Gross Monthly Income**
Wages (patient)			Social Security (patient)		
Wages (additional)			Social Security (additional)		
Self-Employment			Investments/Interest		
Pension/Dividends			Child Support/Alimony		
Tips/Commission			Tribal Income		
Unemployment			Rental/Land Contract Income		
Worker's Compensation			Public Assistance Income		
Disability			Other		

Household Assets (List assets for all household members) This section is NOT REQUIRED for NHSC or MSLRP clinics					
Asset Source	**Who owns this asset?**	**Current Asset Value**	**Asset Source**	**Who owns this asset?**	**Current Asset Value**
Checking Account			Property (home) Value		
Checking Account #2			Property #2 Value		
Savings Account			Vehicle (primary) Value		
Savings Account #2			Vehicle #2 Value		
CD's/Money Market			Motorcycle/ATV/Boat/ Trailer		
401k/403B/IRA/Retirement			Life Insurance (surrender value)		
Stocks/Bonds/Annuity			Trust Fund		
HSA/FSA			Mobile/Virtual Payment Services		
Other			Other		

I understand that the information submitted concerning my annual income, family size and assets, is subject to verification. I also understand that if the information submitted is determined to be false, this will result in a denial of this application and the account balance due will remain my responsibility.

If you have questions or need assistance completing this application, please contact us by phone at 844.408.4103 or email at SHLfinancialcounseling@spectrumhealth.org.

Applicant signature _____ Date _____

Spouse signature _____ Date _____

Spectrum Health Lakeland | **Financial Counseling** | 1234 Napier Ave., St. Joseph, MI 49085