Financial Assistance Application
Bronson Healthcare Group
Patient Accounting, Attn: SP
601 John Street, Box J
Kalamazoo, MI 49007
1-800-699-6117

Date: ____________________

Responsible Party Information		
First Name	Last Name	HAR/Responsible Party

Dear Applicant,

Thank you for your interest in Bronson Healthcare Financial Assistance. Enclosed is the application for Financial Assistance. The following information is a check list of verification items needed from you. If married, be sure to also include verifications for your spouse. Please check either the **Yes** or **No** box for each item, based on whether or not it applies to your situation.

Yes	No	Description of Required Verifications
		Recent copy of pay stub(s) displaying 4 weeks of income and full YTD income, or signed verification letter from employer showing this information
		If self-employed, prior year's personal tax return and tax return for the individual's business, including all schedules
		If unemployed, all year to date unemployment check stubs or a print-out from the state website showing year to date income, or verification of denial showing ineligibility for unemployment benefits
		If receiving Social Security benefits, provide check stub(s), bank statement showing direct deposit, or copy of letter showing monthly benefit
		Documentation of other income (child support, pension, VA benefits, rental or educational income, worker's compensation, etc.) as outlined in the Bronson Financial Assistance Application
		Medicaid Denial Letter from Department of Human Services
		Other:____

Bronson Healthcare Group reserves the right to request additional documentation from you before making a final financial assistance determination. This could include, but is not limited to, a Medicaid denial letter, bank statements, proof of assets, driver's license or state ID, and disclosure of claims and/or income from personal injury and/or accident related claims.

A postage paid envelope is provided for your convenience.

Thank you,

For details or assistance, please contact the Bronson Billing Department at 269-341-6117 or 1-800-699-6117 Monday-Friday 8:30 a.m. to 5:30 p.m.

Financial Assistance Application

To be considered for financial assistance, please complete both pages of the enclosed application and include requested proof of income documents that apply to you and your spouse (if applicable), listed in the "Income" section. If after you submit the application Bronson determines more information is needed, you will receive a letter with the details describing what is needed. You will be notified in writing of our decision within 30 business days of Bronson receiving the completed application. The program covers emergent and medically necessary services provided by Bronson Healthcare Group. The program may or may not cover medical bills you may have with other providers; please contact them directly to see what financial assistance programs they may have to offer. Court costs, filing fees, interest and attorney fees from one of our collection agencies are not covered or paid by this program.

If you have any questions about the application or need assistance completing it, contact the Bronson Billing Department at 269-341-6117 or 1-800-699-6117 Monday – Friday 8:30 a.m. to 5:30 p.m.

Please return the completed application in the envelope provided to:
Bronson Methodist Hospital
Patient Accounting Attn: SP
601 John St, Box J
Kalamazoo, MI 49007

SECTION ONE: PATIENT INFORMATION

Please complete all of the below information regarding demographics and insurance information

Account Number: ______________________ Date(s) of Service: ______________________

Name: ____
LAST NAME FIRST NAME MIDDLE NAME

Address: ______________________ City: ______________ County: ______________
NUMBER AND STREET

State of Residence: __________ Zip Code: ______ Social Security Number: ___/___/_____ Date of Birth: ___/___/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced Home Phone: (   ) __________

Are you a legal resident of the United States? ☐ Yes ☐ No Other Phone: (   ) __________

Name of Employer: ______________________ ☐ Patient ☐ Spouse ☐ Other

Name of Employer: ______________________ ☐ Patient ☐ Spouse ☐ Other

Did you have health insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ☐ Yes ☐ No

Name of Insurance: ______________________ Effective date of insurance: ___/___/_____

Subscriber Name: ______________ Subscriber ID: ______________ Group Number: ______________

SECTION TWO: HOUSEHOLD

Please provide the below information for all immediate family members who live in your home.
- For these purposes family includes the patient's spouse, patient's children under 18 (natural or adoptive) who live in the home.
-If the child(ren) are over the age of 18 and claimed on current year taxes, child(ren) can be listed. Taxes must be included to show proof

Family Member Name(s)	Date of Birth	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		

SECTION THREE: INCOME

Provide any below proof of income that applies for yourself, your spouse and all other family members

Income Source	Current Monthly Gross Income - Patient	Current Monthly Gross Income - Spouse/Other	Total Monthly Family Income	Proof of income (for below applicable sources)
Wages	$	$	$	Recent pay stub(s) showing at least 4 weeks' income and pay stub(s) showing full year to date income, or signed income verification letter from employer(s) documenting this information
Self-Employment	$	$	$	Copy of last year's personal and business tax return including all schedules
Child Support or Alimony	$	$	$	Copy of current court documentation, printed confirmation from Friend of the Court, or check copies/bank statement documenting year to date income
Social Security/Pensions	$	$	$	Copy of benefit award letter, check stub(s), or bank statement showing monthly deposit
Dividends, Interest, Rental Income	$	$	$	Dividend/Interest statement, rental income statement or copy of last year's tax return showing dividend, interest or rental income
Unemployment; Workers' Comp	$	$	$	Year to date unemployment benefits documented with full years' pay stub(s) or a print out from the state website showing year to date income or a denial letter showing ineligibility; Workers' Compensation benefit letter showing year to date income
Veterans benefits	$	$	$	Veterans benefits letter
Other Income	$	$	$	Bank statement or documentation showing any other income (education-based income, misc. income, etc.)
TOTAL	**$**	**$**	**$**	

If no income, please briefly describe how basic living needs are being met and who is providing the support.

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SECTION FOUR: ASSETS

Please list all assets that apply for yourself, your spouse and all other family members

Asset Type	Current Balance for Patient	Current Balance for Spouse/Other
Bank Account - Savings	$	$
Bank Account - Checking	$	$
Stocks, Bonds, Funds	$	$
HSA/FSA Account	$	$
TOTAL	**$**	**$**

SECTION FIVE: ATTESTATION

Please read the below section carefully and sign and date in the designated areas

I understand the information I submit to Bronson will be verified. I give permission to Bronson Healthcare Group to access my credit report if needed. I also understand that Bronson Healthcare Group may ask for more information, for example proof of assets, bank statements, or a Medicaid denial letter if it is needed to decide eligibility. This application may be denied if I do not provide the requested documents. Bronson Healthcare Group reserves the right to reverse any adjustment if payment becomes available.

I have carefully read this application and all of this information I have provided is true.

Signature of Financially Responsible Party ____________ Date ____________ Relationship to Patient (If Not Self) ____________

Signature of Spouse ____________ Date ____________