WAYNE HEALTH

Billing and Financial Assistance Form

Patient Information

First name* | Last name* | Birth Date*

Address*

Street Address | State / Province / Region

City | ZIP/Postal code

Social Security Number* | Telephone*

Email*

Responsible Party Information

Name and Address*

Social Security Number* | Telephone*

Employer Name & Address*

Telephone* | Occupation* | Employment Length* | Monthly Salary*

No. of Dependents* | Driver's License Number or State Issued Identification*

Preferred Language*

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Spouse Information

Name and Address*

Social Security Number*

Telephone*

Family Group Living in Home

Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age

Health Insurance Information

Insurance Company*

Subscriber

Premium (If Applicable)

Eligibility Date

Policy & Group #s

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Did you apply for insurance through the Health Insurance Marketplace?*

☐ Yes ☐ No

Do you receive assistance with medical bills? (ie: Access Health, Amish, County Health Dept., Church, Indian Reservation, Sliding-fee Scale or Tencon)*

☐ Yes ☐ No

Are you seeking medical services as a result of violent crime inflicted by another person?*

☐ Yes ☐ No

Are you seeking medical services due to an accident, motor vehicle or otherwise?*

☐ Yes ☐ No

Assets/ Expenses

Residence (Monthly Mortgage/ Rent Payment)	Monthly Payment	Value	Unpaid Balance
Second Residence / Vacation Home	Monthly Payment	Value	Unpaid Balance
First Auto*	Year Make	Monthly Payment	Unpaid Balance
Second Auto	Year Make	Monthly Payment	Unpaid Balance

No Monthly Income (Patients with no income or expenses significantly exceeding income, please provide)*

Name of person providing food, shelter and other living expenses	*Phone number	* Relationship of applicant

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Monthly Household Liabilities/Expenses

Rent / Mortgage, Balance*

Grocery Expense*

Child Care*

Child Support / Alimony

Utilities: Gas

Utilities: Electric

Utilities: Water/Sewer

Utilities: Other

Telephone: (Mobile/Cell/Home etc.)

Medication Expenses
(co-pay / cash pay etc.)

Health Insurance Premiums

Car Loan Payments

Unpaid Medical Expenses (i.e. doctor, dental, hospital, other providers) Please provide a detailed list with copies of most recent bills if available

Transportation (Bus, Taxi)

Loan Payment Type

Loan Payment Balance

Credit Card Payment(s) Total Balance(s) Owed

Monthly Income

Total Household Income*

Child Support*

Alimony*

Workers's compensation*

Unemployment*

Social Security / Disability*

Unemployment Date / Length

Rental

Land Contract

Divident / Interest

Trust Fund

Public Assistance*

Retirement / Pension

Bank Name

Bank Location

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☐ **I understand this form must be completed in full and have all required documents attached when returned by me so Wayne Health can determine if I qualify for financial assistance. If it is not complete, I will receive a written notice that describes the additional information and/or documents required. I have provided true and accurate information, and I agree that Wayne Health may investigate this information.**

Applicant Signature _____ **Date** _____

Applicants will also need to provide the following required documentation

- Federal Income Tax Return for the most recent tax year (Form 1040), including all applicable schedules
- Most recent Wage and Tax Statements (Form W-2) and/or Miscellaneous Income (Form 1099)
- Recent copy of the last 2 months of pay stubs with year-to-date earnings for each member of the household or a statement from the employer verifying gross wages
- Proof of other income (i.e. rental property, etc.)
- Recent copy of the last 2 months of bank statement of checking/savings accounts
- Copy of valid Michigan driver's license or Michigan state identification card
- If applicable, a denial response from Medicaid, Marketplace, and/or COBRA documentation
- Personal statement of financial need from the patient or responsible party