Financial Assistance Application
Date Received _____

Van Buren County Hospital
Simply Remarkable
An Affiliate of MERCYONE

Section 1: Patient and Guarantor Information

Patient Name:_____ Date of Birth: _____/_____/_____

Guarantor Name (if patient is a minor)_____ Phone Number_____

Address_____ City_____ State_____ Zip Code_____

Name(s) of Spouse and additional dependents (Use additional page if you need more room)	Date of Birth	Relation to Patient

Section 2: Insurance Information

Name(s) of your insurance company:_____

Section 3: Income Information

Source of Income	Gross Income for Prior 12 Months	Gross Income for Prior 12 Months for Spouse or Other Household Member (s)	**Please Include the most recent copy of the items below**
Wages Self Employed			Last 3 paystubs Recent Tax Return
Social Security			Social Security Benefit Letter
Pension/Disability Rental Income			Pension/Disability Letter Tax Return with schedules
Unemployment Workers' Compensation			Unemployment Letter Workers' Compensation Letter

If you have $0 income, please provide your last date of employment and tell us how you meet basic living needs:

_____

_____

By signing this form, I agree that:

- I am requesting VBCH to determine if I am eligible for assistance in paying my bill.
- The information in this form is correct and VBCH may confirm its accuracy.
- Filling out this form does not guarantee assistance and if I am not eligible based on VBCH guidelines I will be responsible for the payment of my bill.

Patient/Guarantor's Signature:_____ Date:_____
Spouse Signature (If Applicable):_____ Date:_____

Your application will not be processed if there is incomplete or missing information