Van Buren County Hospital

Financial Assistance Application

It is the policy of Van Buren County Hospital to provide essential services regardless of the patient's ability to pay. Discounts are offered based on the family size and annual income. Please complete the following information and return to the business office to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this hospital and clinics, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs and x-ray interpretation by a consulting radiologist and other such services. This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, Survivor benefits, pension or retirement income				
Interest ,dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

W-2s from prior 12 months for all members of the patient's household
The most recent tax returns of all members of the patient's household
The most recent statements for all financial accounts owned by the patient or members of the patient's household, including, but not limited to bank statements and other investment accounts
Additional financial verification

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I understand that the County and Hospital are required by law to keep all information I provide confidential.
- I further agree that in consideration for receiving services as a result of an accident or injury, to reimburse the county or hospital from proceeds of any litigation or settlement.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the service rendered by the Hospital. I may appeal the decision in writing with additional documentation within 30 days

I the undersigned, request the Hospital to determine if I am eligible for assistance in paying my hospital bill. I understand that I need to give certain information for this to be done. I also understand that the hospital will verify the facts for accuracy. I understand that filling out this form does not guarantee that I will receive assistance. If I am not eligible based on the Hospital guidelines, I will be responsible for the payment of my bill.

I certify that the family size and income information shown above is correct.

_____ _____

Signature Date

_____ _____

Spouse Signature (If Applicable) Date

Office Use Only

Patient Name: _____

Accounts: _____

Approved Discount: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's License, utility bill, employment ID, Other		
Income: Prior year tax return, three most recent pay stubs or other		
Insurance: Insurance Cards		