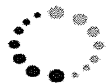


North Ottawa
Community Hospital
1309 Sheldon Road, Grand Haven, MI 49417
616.842.3600

FINANCIAL ASSISTANCE VERIFICATION CHECKLIST

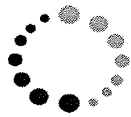
- ☐ Application for Hospital Financial Assistance
- ☐ Medicaid Determination
- ☐ Marketplace Attestation

INCOME VERIFICATIONS

- ☐ Employment Income
  (Past 30 days consecutive check stubs showing gross amount)
- ☐ Self-employed, rental or farm income
  (Previous year tax documents (1040 form with Schedule, C, E or F)
- ☐ Social Security Income
  (Please provide proof)
- ☐ Unemployment Income
  (Please provide proof)
- ☐ Child Support Income
  (Court document showing awarded amount)
- ☐ Pension or Monthly Annuity Payments
  (Please provide proof)
- ☐ Seasonal Employment Income
  (Previous year's W2 form)
- ☐ No Income
  (Letter of Support completed by person providing you with food and/or shelter)

ASSET VERFICATIONS

- ☐ Savings/Checking Account
  (Past 60 days bank statements for each account)
- ☐ CDs, Money Markets
  (Past 30 days statement showing current balances in each investment)
- ☐ Any investments you receive monthly income from
  (Past 30 days bank statement showing direct deposits or award letter)



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(For Hospital Use Only)	
Account #s: ______________	
Date: ______________	
Pending:	☐
Approved	☐
Denied	☐

CONFIDENTIAL APPLICATION FOR HOSPITAL FINANCIAL ASSISTANCE

Professional services provided by affiliated physician or other providers may be billed separately.

Patient Name		Date of Birth
Street Address		Telephone
City/St/Zip		Social Security #

Please provide the following for ALL household members:

NAME	Date of Birth	Relationship to Patient

Application

Do you have Insurance	☐ NO	☐ YES	If Yes, Name/ID	
If NO, Did you apply for insurance through the Health Insurance Marketplace (please supply proof)	☐ NO	☐ YES	Please select reason enrollment was not completed and provide documentation if available	☐ I did not qualify ☐ I cannot afford the premium ☐ I am exempt from penalties ☐ Other—please include letter of explanation with application

Do you have Medicaid	□ NO	□ YES	If Yes, Name/ID	
Have you applied for disability?	□ NO	□ YES	If Yes, When?	

Assets		**Value**
Cash on hand		$
Checking Account Balance	Bank:	$
Savings Account Balance	Bank:	$
Retirements Savings	Bank:	$
Investments or Other Securities i.e. stocks or bonds		$
Life Insurance Policy Cash Value		$
Real Estate other than Primary Residence	Location:	$

Total Assets $______________________

List vehicles owned below: (include cars, trucks, snowmobiles, RV's motorcycles, etc.)

Type of Vehicle	Year	Value (approximate)
		$
		$
		$

Total Assets

$______________________ Employment

Person Employed	Employer	Gross Pay	Per:	Monthly Gross
			□Wk. □2Wk □Month	
			□Wk. □2Wk □Month	
			□Wk. □2Wk □Month	

Monthly Household Income from Other Sources

Source	Monthly	Annually
Child Support/Alimony	$	$
Federal Assistance Program Type__________________ (i.e. Cash, Bride Card, etc.)	$	$

Pension / IRA / 403(b) / Annuity Cash out	$	$
Social Security / Social Security Disability	$	$
Unemployment or Workers Comp (Start Date: MM/DD/YY End Date MM/DD/YY)	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Total Monthly Gross Income from Other Sources	$	$

VERIFICATION OF INCOME AND IDENTIFICATION

I hereby authorize North Ottawa Community Health System to release information on file to assist in the enrollment of various health and human service programs for which I apply. I understand this information may include financial information, medical information and/or any other information contained in my file.

The U.S. Department of Health and Human Services (HHS) enforces the federal privacy regulations commonly known as the HIPAA Privacy Rule (HIPAA). HIPAA requires most doctors, nurses, pharmacies, hospitals, nursing homes and other health care providers to protect the privacy of your health information. Even though HIPAA requires health care providers to protect your privacy, providers are permitted, in most circumstances to communicate with the patient's family, friends, or others involved in their care or payment from care.

I hereby authorize North Ottawa Community Health System to use the information provided on my Medicaid application to determine my eligibility for financial assistance. I understand that I may be asked to provide additional information and documentation to complete my financial assistance application.

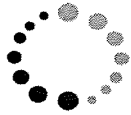
I hereby certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I also understand that I will be liable for repayment of any services rendered at North Ottawa Health System if the above information is given under false pretenses.

SIGNATURE

____ **DATE**______________

SPOUSE SIGNATURE (if applicable)

____ **DATE**______________



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Account #s: ____________________

Date: ____________________

Financial Assistance Documentation – Letter of Support

I____state that____________________________
Person signing Letter of Support (please print)   Patient Name (please print)

With a date of birth of______________________:

(Check all situations applicable below)

______currently lives with me at

_____________________________________ ____________________ ______ ____________
Address   City   State   Zip

______I provide food and shelter but I am unable to provide assistance for medical bills.

______I provide financial support *when* possible.

______I provide monthly financial support in the amount of $__________________.

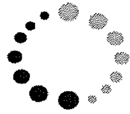
By signing this letter I verify that the above statement (s) is (are) correct and that I will in no way be held liable for the patient's bills. If you have questions please contact me at ___________________________.

_____________________________ _____________________________ ______________
Signature of person providing support   Relationship to Patient   Date

Patient Signature

Date

PA-5505 (5-14)



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Account #s: ____________________

Date: ________________________

Health Insurance Marketplace Attestation

I certify that:

□ I have completed my enrollment in the Marketplace.

Insurance Plan Name: ____

Effective Date: ____

□ I have made the decision to not enroll in the Marketplace.

□ I have enrolled in the Marketplace and received a determina on declaring that I will not be penalized for not enrolling in coverage due to my current financial situation.

□ I have applied for this insurance and I am ac vely appealing the determina on that was made. I understand I am required to contact North Ottawa Community Health System upon receipt of the appeal decision.

By signing this document I verify that the above statements are true. I understand that if the information above is found to be falsified, any financial assistance received based on this statement may be revoked and I will become responsible for repayment of any of these previously adjusted balances.

____ ____________________________

Application Signature Date

____

Application Date of Birth

PA-5508 (5-14)