McLaren
HEALTH CARE

Financial Assistance Application Instructions

We will provide Financial Assistance for Medically Necessary services for patients who qualify.

Qualification for financial assistance will be based on the Federal Poverty Guidelines (published annually in the Federal Register). Patients who indicate that they do not have insurance or any other means of paying for medically necessary services may request consideration for Financial Assistance.

PLEASE RETURN THE FOLLOWING DOCUMENTS:

- **COMPLETED FINANCIAL ASSISTANCE APPLICATION** (incomplete ones will not be considered)
- **PROOF OF HOUSEHOLD INCOME**
  Michigan Residents: Last 4 check stubs and 2 bank statements or other proof of income
  Ohio Residents: 3 months proof of income
- **INCOME VERIFICATION FORM** (IF YOU CURRENTLY DO NOT HAVE ANY INCOME)
- **COPY OF LAST FILED FEDERAL TAX RETURN**
- **PLEASE NOTE IF ANY DOCUMENTATION IS UNATTAINABLE**

McLaren Health Care may request additional financial documents necessary to process the Financial Assistance Application.

PLEASE RETURN THE COMPLETED APPLICATION AND SUPPORTING DOCUMENTS WITHIN FOURTEEN (14) DAYS TO:

McLaren Corporate Services
Attn: Revenue Cycle Operations - Customer Service
50820 Schoenherr Rd.
Shelby Township, MI 48315

OR FinancialAssistance@mclaren.org

All requested information must be returned in order to be processed/reviewed for Financial Assistance. If you have any questions or need any assistance with completing the application please contact:

Patient Financial Services
Customer Services Department
(844) 321-1557

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Income Verification Form

This form should only be used when the applicant for Financial Assistance lists no income.

All fields on this form must be completed for the form to be valid.

Applicant Name:	Applicant Current Address:

Applicant Income Verification
I, _____, certify that I have no earned or unearned income. I give McLaren Health Care permission to verify this statement. I understand that if McLaren Health Care finds that I have earned or unearned income, I will be disqualified from receiving financial assistance. I am currently being supported by (list how you are meeting basic expenses, food, clothing, shelter, including the names of all individuals providing support): _____ _____ _____ _____ _____ I understand that a representative from McLaren Health Care may contact the individuals listed above to verify the information provided.

Signature
Applicant Signature: _____ Printed Name: _____ Date: _____