

Instructions: Complete application, return within 10 days, and attach copies of:

- Most recent tax return
- Three months complete bank statements
- Medicaid determination/denial, if applied
- Current Statements for all investments
- Three months proof of income (pay stubs, etc.)
- If no income, a letter from party providing support

Patient Information (Print)			
Name (Last, First, Middle Initial)		Date of Birth	
Address			
Primary Phone () ()	Secondary Phone () ()	Social Security/EIN	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____		Are you a documented resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you file a Federal Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why? _____		Who is the primary filer? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	
Employer		Did you have health insurance or any other coverage at the time of your service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Household Information (List all people who live in your household)			
Name of Household Member	Date of Birth	Relationship	Is this person listed on your Federal Tax Return?
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No
5.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any additional household members can be submitted on additional paper.			
Expenses (List monthly expenses for all household members) This section is NOT REQUIRED for NHSC or MSLRP clinics			
House Payment/Rent/Lot Rent	Property Taxes (year)	House/Rental Insurance	
Car Payment	Car Insurance	Fuel (vehicle)	
Phone	General Utilities	Groceries	
Childcare/Child Support	Tuition	Other	
Health Insurance/Expenses	Life Insurance	Other	

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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Income (List income for all household members)					
Monthly Income Source	Who receives this?	Gross Monthly Income	Monthly Income Source	Who receives this?	Gross Monthly Income
Wages (patient)			Social Security (patient)		
Wages (additional)			Social Security (additional)		
Self-Employment			Investments/Interest		
Pension/Dividends			Child Support/Alimony		
Tips/Commission			Tribal Income		
Unemployment			Rental/Land Contract Income		
Worker's Compensation			Public Assistance Income		
Disability			Other		

Household Assets (List assets for all household members) This section is NOT REQUIRED for NHSC or MSLRP clinics					
Asset Source	Who owns this asset?	Current Asset Value	Asset Source	Who owns this asset?	Current Asset Value
Checking Account			Property (home) Value		
Checking Account #2			Property #2 Value		
Savings Account			Vehicle (primary) Value		
Savings Account #2			Vehicle #2 Value		
CD's/Money Market			Motorcycle/ATV/Boat/Trailer		
401k/403B/IRA/Retirement			Life Insurance (surrender value)		
Stocks/Bonds/Annuity			Trust Fund		
HSA/FSA			Mobile/Virtual Payment Services		
Other			Other		

I understand that the information submitted concerning my annual income, family size and assets, is subject to verification. I also understand that if the information submitted is determined to be false, this will result in a denial of this application and the account balance due will remain my responsibility.

If you have questions or need assistance completing this application, please contact us by phone at 877.687.7309 or email at EastFinancialCounseling@corewellhealth.org.

Applicant signature _____ Date _____

Spouse signature _____ Date _____