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TO: _____ Date Received by Office: _____

DATE: _____

Data Check
Date _____/Int._____
MPHI [ ] Not on File **or** _____

FROM: Traverse Health Clinic
1719 S Garfield Ave
Traverse City, MI 49686

SUBJECT: **APPLICATION FOR FINANCIAL ASSISTANCE – Traverse Health Clinic**

As part of the enrollment process for the Traverse Health Clinic (THClinic) programs and services, **you must provide financial information and documentation as outlined below.** Please submit **ALL** of the following information listed below by _____. **Any missing documentation will result in your application being denied. Failure to disclose all means of income will cause ineligibility for assistance.**

The Traverse Health Clinic offers a Sliding Fee Scale, determined by family size and income, on the patient fees. *Those that are eligible for Medicaid and Medicare are strongly encouraged to apply directly to those programs.* Because we work with Munson Uncompensated Care, this financial information **will be shared with Munson Healthcare.**

NEEDED INFORMATION:

- Financial application (enclosed).

- Proof of income includes –
  - ☐ Copies of Pay stubs for any jobs held (three previous months) for responsible party and spouse.
  - ☐ Alimony (three previous months)
  - ☐ Unemployment/Worker's Comp Award Letter (dated within last 6 months)
  - ☐ Social Security Benefit Letter (for current year)
  - ☐ Pension / Retirement (for current year)
  - ☐ Income from Rents, Royalties, Estates, Trusts
  - ☐ VA Benefits (for current year)
  - ☐ Written and Signed Statements from employer verifying CASH income (i.e. Babysitting. House cleaning, etc)
  - ☐ Self-employed clients must provide their Schedule C from their most recent Federal Tax Return.
  - ☐ Clients with no income who receive financial support must provide a letter from the source detailing the support provided.
  - ☐ Self-Declaration of Income (available upon request/based on circumstances)

- Page 1 and 2 of your most recent Federal Tax Return (1040)

- Any other information that the Traverse Health Clinic deems necessary.

If you are completing this application for yourself and another household member (spouse, dependent, etc.) please be aware that we need the signatures of all applicants where indicated.

Thank you – Traverse Health Clinic Staff

In any spaces that DO NOT apply to you, please list "na".

If a space is left blank it will require follow up. **Thank you!**

Name(s): _____

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TRAVERSE HEALTH CLINIC -Financial Application

If this is a joint application please complete for both household members

PATIENT'S LEGAL NAME:		**BIRTHDATE:**	
1. _____		1. _____	
2. _____		2. _____	
STREET ADDRESS (no P.O. Boxes):	**CITY:**	**COUNTY:**	**ZIP:**
SSN:		**PHONE:**	
1. _____		1. _____	
2. _____		2. _____	

LIST ALL PERSONS LIVING IN YOUR HOUSEHOLD:

NAME	AGE	RELATIONSHIP

EMPLOYMENT INFORMATION:

Current Employment Information – Patient (if you have more jobs and need more space, attach another sheet of paper):

If employed, answer the following questions:

Employer name_____

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$_____

Average hours worked each WEEK_____

If self-employed, answer the following questions:

Type of business_____

Business name_____

Business address_____

Gross monthly income (before expenses)_____

Monthly business expenses_____

Name(s): _____

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Current Employment Information – Spouse (if your spouse has more jobs and needs more space, attach another sheet of paper):

If employed, answer the following questions:

Employer name_____

Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$_____

Average hours worked each WEEK_____

If self-employed, answer the following questions:

Type of business_____

Business name_____

Business address_____

Gross monthly income (before expenses)_____

Monthly self-employment expenses_____

OTHER MONTHLY INCOME: Please list all that apply to you or your spouse, give the amount and how often you receive the income. NOTE: You do not need to include information about child support/Supplemental Security Income (SSI).

TYPE OF INCOME	PATIENT	SPOUSE	HOW OFTEN?
Unemployment/Worker's Comp			
Pension/Retirement			
Social Security			
VA Benefits			
Alimony			
Rent/Royalty/Estate/Trust			
Other Income			

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING: I do hereby acknowledge that all the information herein is true. I authorize Traverse Health Clinic and/or Munson Healthcare to obtain a credit report for financial assistance if needed. I also authorize Traverse Health Clinic to share this information with charitable organizations for determining benefits

Signature of Client/Responsible Party: _____ Date: _____

Signature of Client/Responsible Party: _____ Date: _____