# COMMUNITY FINANCIAL ASSISTANCE APPLICATION

Mary Free Bed Rehabilitation

Attached is Mary Free Bed Rehabilitation Hospital's Community Financial Assistance Application Form (CFA-3). If you are interested in applying for financial assistance at Mary Free Bed Rehabilitation Hospital, please complete all sections as directed on the application form and be sure to send in the requested supporting financial documentation for all household members.

**APPLICATION MUST BE RETURNED BY** ____/____/_____

**Supporting financial documentation requested:**

- Proof of employment, including two months' recent pay stubs, or
- Proof of unemployment
- Proof of Medicaid application and/or denial
- Copy of the current and/or previous year federal 1040 tax return
- Copies of state assistance papers (if applicable)
- Copies of any household assets, as described in Section 4 (if applicable)
- Proof of any other income sources, as described in Section 6 (if applicable)
- Name of Referring Physician: _____

Once this information is received in our office, your application will be reviewed for determination of approval.

Please contact Mary Free Bed Rehabilitation Hospital Financial Counseling Department at 616.840.8252 with any questions that you may have regarding the application process.

We look forward to assisting with your health care needs!

# COMMUNITY FINANCIAL ASSISTANCE APPLICATION (CFA-3)

(For Hospital Use Only)

FIN #s:

Dept:

Who Requested:

Mary Free Bed Rehabilitation

Network Service Location

Click the arrows to select a program name.

(For Hospital Use Only)

Date:

Approved 100% ☐ 80% ☐ 60% ☐ 40% ☐

CFA: Approved ☐ Denied ☐

I understand that Community Financial Assistance is awarded after Mary Free Bed conducts clinical and financial review, and may or may not be approved based on this review. I understand that the information provided in this application is subject to verification by Mary Free Bed. I also understand that if the information provided is determined to be false, my application for assistance may be denied and the account balance due will remain my responsibility.

## SECTION ONE: PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Dates of Service(s): | Date of Birth: |
| Street Address: | Home Phone: | Primary/Cell Phone: |
| City/State/Zip: | | Social Security Number: |
| Email address: | | |

| | | |
|---|---|---|
| Marital Status ☐ Single ☐ Legally married ☐ Divorced ☐ Other | Are you a legal resident of the United States? ☐ Yes ☐ No | Did you have health insurance or any other coverage at the time of your service? ☐ Yes ☐ No |
| Do you file a Federal Tax Return? ☐ Yes ☐ No<br>If No, why? _____ | Who is the primary filer?<br>☐ Self ☐ Spouse ☐ Other | Does anyone in the home receive public assistance?<br>☐ Cash ☐ Food ☐ Other _____ |

## SECTION TWO: APPLICATION

| | | | |
|---|---|---|---|
| Do you have health insurance? | ☐ Yes | ☐ No | If Yes, Name/ID: |
| If No, did you apply for insurance through the Health Insurance Marketplace? | ☐ Yes | ☐ No | 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 – include letter of explanation with application |
| Do you have a Health Savings Account? | ☐ Yes | ☐ No | |
| Do you have a Health Reimbursement Account such as Christian Healthcare Ministries? | ☐ Yes | ☐ No | |
| Do you have a Flexible Spending Account? | ☐ Yes | ☐ No | |
| Do you have Medicaid? | ☐ Yes* | ☐ No | *IF YES STOP! provide the Medicaid ID number: then skip to page four, sign, date and submit this document to Mary Free Bed for review. No additional documentation is necessary at this time. |
| If No, have you applied for Medicaid? | ☐ Yes | ☐ No | |
| Do you receive assistance with medical bills? (i.e; Amish, County Health Dept., Church, Indian Reservation, Sliding-fee Scale) | ☐ Yes | ☐ No | If Yes, Name/ID: |



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| | | | |
|---|---|---|---|
| Other Charity Sources (i.e; Crowdfunding, other donation-based accounts) | ☐ Yes | ☐ No | If Yes, Explain: |
| Do you have Medicare? | ☐ Yes | ☐ No | If Yes, Name/ID: |
| Is anyone in the household a veteran? | ☐ Yes | ☐ No | If Yes, Name: |
| Is there a member of the household who became unemployed within the past 90 days? | ☐ Yes | ☐ No | If Yes, Name: |
| Were health benefits received by this person? | ☐ Yes | ☐ No | If Yes, Name of insurance company: |

SECTION THREE: HOUSEHOLD MEMBERS (List legally married spouse and all dependents included on tax return)

| Name: | Date of Birth: | Relationship to Patient: | Is this person listed on your Federal Tax Return? |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

SECTION FOUR: HOUSEHOLD ASSETS (List assets for all household members) Supporting documentation must be provided for consideration

| Asset Source | What household member owns this asset? | Current Asset Value | Asset Source | What household member owns this asset? | Current Asset Value |
|---|---|---|---|---|---|
| Checking Account | | | | | |
| Checking Account #2 | | | Other: | | |
| Savings Account | | | | | |
| Savings Account #2 | | | | | |
| HSA/FSA | | | | | |
| IRA/401K/Investment Accounts | | | | | |

SECTION FIVE: EMPLOYMENT (MUST INCLUDE CHANGES TO INCOME IN THE LAST SIX MONTHS) Supporting documentation must be provided for consideration

| Person Employed/Self Employed | Employer | Gross Pay* | Per: | Monthly Gross** |
|---|---|---|---|---|
| | | | ☐ Wk ☐ 2Wk ☐ Month | |
| | | | ☐ Wk ☐ 2Wk ☐ Month | |
| | | | ☐ Wk ☐ 2Wk ☐ Month | |

*If self employed please list net income/loss
**If self employed, please list monthly net



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| SECTION SIX: MONTHLY HOUSEHOLD INCOME FROM OTHER SOURCES | | |
|---|---|---|
| Source | Monthly | Annually |
| Child Support/Alimony | $ | $ |
| Federal Assistance Program Type<br>_____ (i.e. Cash, Food Stamps, etc.) | $ | $ |
| Pension / IRA / 403(b) / Annuity Cashout | $ | $ |
| Social Security/SSI/SSDI | $ | $ |
| Unemployment/Workers' Comp/Auto Insurance Wage Loss Income<br>(Start Date: MM/DD/YY End Date: MM/DD/YY) | $ | $ |
| Other Income (Stocks/Bonds/Annuities/Interest/Rental Property/Any other income) | $ | $ |
| Total Monthly Gross Income from Other Sources | $ | $ |

If you would like to provide a brief summary of your financial circumstances, please complete section seven on the following page.

I hereby affirm that the above information is correct to the best of my knowledge. I authorize Mary Free Bed to verify any information for completeness and accuracy. I further authorize such information to be available for release to Mary Free Bed.
I certify my typed name (below) represents my signature and signifies my consent.

SIGNATURE _____ DATE _____

PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____
(if applicable)



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SECTION SEVEN: APPLICANT SECTION (OPTIONAL):

In the area below, please briefly explain any financial circumstances not adequately addressed within the application form.

SECTION EIGHT: CLINICAL NOTES (OPTIONAL):

**END**