Orthopaedic Associates of MICHIGAN

Confidential Application for Financial Assistance

Orthopaedic Associates of Michigan (OAM) offers financial assistance for medical care provided at all of our medical facilities. Based on your financial need, either reduced payments or free care may be available.

You may be eligible for financial assistance if you:

- Have limited or no health insurance.
- Are not eligible for government assistance.
- Can show you have financial need.
- Provide OAM with necessary information about your household finances.
- Have medical expenses in an amount that exceeds your ability to pay as determined by OAM guidelines.
- Have been approved for Financial Assistance at another local health system.

To apply for OAM financial assistance, please follow these steps:

1. You must explore whether you are eligible for some type of insurance benefits that would cover your care (such as workers compensation, automobile insurance, or medical assistance). We can show you how to find the right resources for these.
2. Complete this OAM financial assistance application form. A checklist is provided at the end of this form to help ensure you have included all supporting documents. A separate application must be completed for each individual requesting financial assistance.

What happens next:

- We will look at your income and family size to determine the level of assistance available to you. We use a sliding scale based on federal poverty guidelines.
- We will get in touch with you to let you know if you are eligible for OAM financial assistance.
- We can help you set up a payment plan for any remaining charges or bills that are not covered by OAM financial assistance.

Patient Information

(Please print)

Name _____ Date of Birth _____
(First, Middle Initial, Last)

OAM Account Number _____ Account Balance _____

Marital Status (circle one): Single Married Domestic partner Divorced Separated Widowed

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Are you employed?

No ____ Yes ____ With whom? _____

Did you have health insurance or any other coverage at the time of service? Yes ____ No ____

Do you file a Federal Tax Return?

Yes ____ No ____ Why not? _____

Who is the primary filer? Self ____ Spouse ____ Other (specify) _____

Does anyone in the home receive public assistance?

No ____ Yes: Cash ____ Food ____ Other (specify) _____

Household Information

Please list everyone who lives in your household (not including yourself). Include children you have partial custody of, foster children, and relatives.

Name	Relationship to Patient	Date of Birth	Listed on Your Federal Tax Return?

Household Income

Please list the *gross monthly* income for everyone who lives in your household (including yourself).

Name:						
Wages, salaries, tips, commission						
Self-employment						
Rental Property income						
Social Security						
Pension/Retirement Fund (401K/403B/IRA) Distribution						
Dividends from Stocks/Bonds/Annuity						
Interest from Savings/Checking/Money Market/Mutual Fund/CD accounts						
Royalties						
Tribal Income						
Worker's compensation						
Alimony/Child Support						
Legal Judgements						
Unemployment compensation						
Other (specify):						

Household Assets

Please list the current asset value for everyone who lives in your household (including yourself).

Name:						
Cash						
Savings Account						
Checking Account						
Money Market/Mutual Fund						
Certificates of Deposit						
Pension/Retirement Fund (401K/403B/IRA)						
Stocks/Bonds/Annuity						
HSA/FSA						
Property (home)						
Property #2						
Vehicle (primary)						
Vehicle #2						
Motorcycle/ATV/Boat/Camper/Jet ski/Snowmobile						
Life Insurance (surrender value)						
Other (specify):						

Monthly Household Expenses

Please round to the nearest dollar.

House payment $ _____
Property Taxes $ _____
Rent/Lot Rent $ _____
House/Rental Insurance $ _____
Health Insurance $ _____
Medical Expenses $ _____
Life Insurance $ _____
Car Payment $ _____
Car Insurance $ _____
Car Fuel & Maintenance $ _____
Gas (for home) $ _____

Electric $ _____
Water/Sewer $ _____
Trash Removal $ _____
Cable/Dish/Satellite $ _____
Internet $ _____
Landline/Cell Phone $ _____
Groceries $ _____
Child Care $ _____
Tuition $ _____
Debt payment $ _____
Other (specify) $ _____

Please provide a detailed description of your circumstances (for example, a recent death of a spouse, divorce or bankruptcy filing):

_____

_____

_____

Supporting Documents Checklist

Your application must include copies of any of the following documents that apply to you. Please send copies (not originals) as OAM cannot return any documents sent with the application. If any documents are missing it will delay the processing of your application.

- ✓ Letter of Denial of Medical Assistance
- ✓ Proof of *household* income which may include:
  - Wages, salaries, tips, commission pay stubs for the last 3 months
  - If self-employed, full tax return with Schedule C and/or profit/loss statement
  - Rental Property income
  - Social Security Form 1099 or award letter
  - Pension/Retirement Fund (401K/403B/IRA)
  - Stocks, Bonds, Annuity account statements
  - Savings, Checking, Money Market, Mutual Fund account statements
  - Royalties
  - Tribal Income
  - Worker's compensation letter
  - Alimony/Child Support
  - Legal Judgements
  - Unemployment compensation letter
  - Most recent IRS Form 1040
- ✓ Proof of *household* expenses which may include receipts or statements for:
  - House payment
  - Property Taxes
  - Rent/Lot Rent
  - House/Rental Insurance
  - Health Insurance
  - Medical Expenses
  - Life Insurance
  - Car Payment
  - Car Insurance
  - Car Fuel & Maintenance
  - Gas (for home)
  - Electric
  - Water/Sewer
  - Trash Removal
  - Cable/Dish/Satellite
  - Internet
  - Landline/Cell Phone
  - Groceries
  - Child Care
  - Tuition
  - Debt payment
  - Other

If you have no income: A letter of support is required. The person who provides your support must sign the letter.

Questions? Please call the Patient Financial Experience Team at (616) 459-2026.

By signing below, I certify that everything I have stated on this application and on all attachments is true.

Patient Signature_____ Date _____

Please submit your application:

- Fax it to: (616) 336-5042, or
- Mail it or bring it to: 1111 Leffingwell Ave. NE, Grand Rapids, MI 49525