FINANCIAL ASSISTANCE APPLICATION

The completion of the following information is required before a determination for financial assistance at South Haven Health System. Please complete the information and return to the cashier office in the main lobby of the hospital or by mail to:

South Haven Health System
Attention: Cashier
955 South Bailey Avenue
South Haven, Michigan 49090

Patient Name: ________________________________Social Sec. #: _________________

Guarantor Name: ___________________________ Social Sec #: _________________

Street Number/Apt #____

City: _____________________ State ________ Zip Code___________

Phone Number: (_____) _______________

Monthly Household Income: $ _________________

Please include proof of income from previous year (Federal Income Tax form) and year to date income for current year (most recent employment income stub).
Please include all household income.

Please indicate the number in household ________.
Please list the names and birthdates of the dependents.

Please indicate any other medical expenses owing to healthcare providers other than South Haven Health System or its Clinics $_____________.
On the reverse side of this form, please list the healthcare providers and the amount due from each.

Self Employed: if you are self employed please provide list of business assets such as vehicles, property, or inventory.

If you have no income, please provide an explanation of your current means of support.

Please **sign** this form indicating that all the information provided is true and accurate.

Signature of Primary Debtor and Date   Spouse Signature and Date