WMCC #_____

Patient Name: _____

200 N. Park Street
Kalamazoo, MI 49007
Phone 269-382-2500
Fax 269-xxx-xxxx
www.wmcc.org

West Michigan Cancer Center

Radiation & Surgical Specialties

FINANCIAL ASSISTANCE APPLICATION FORM

Date: _____

Dear Applicant,

Thank you for your interest in the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) financial assistance program. Enclosed is the application for Financial Assistance. The following information is a checklist of verification items needed from you. If you are married, be sure to also include verifications for your spouse.

You (and your spouse, if applicable) will also need to include:

- Recent copy of pay stub(s) displaying four (4) weeks of income and full year-to-date (YTD) income or signed verification letter from employer on company letterhead showing this information.
- If self-employed, prior year's personal tax return(s) and tax return for the individual's business included all schedules.
- If unemployed, all year-to-date unemployment check stubs or a print-out from the state website showing year-to-date income, or verification of denial showing ineligibility for unemployment benefits.
- If receiving Social Security benefits, provide a copy of the letter showing the monthly benefit.
- Documentation of other income (child support, pension, VA benefits, rental or educational income, worker's compensation, etc).
- Medical Denial Letter from Department of Human Services.

The West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) reserves the right to request additional documentation from you before making a final financial assistance evaluation. This could include, but is not limited to a Medicaid Denial Letter, bank statements, proof of assets, driver's license or State ID and disclosure of claims and/or income from personal injury and/or accident related claims.

For details or assistance, please contact the Patient Financial Counseling Department at 269-382-2500 Monday – Friday, 8:00am to 5:00 pm.

Thank you,

WMCC Billing

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To be considered for financial assistance, please complete all pages of the enclosed application and include requested proof of income documents that apply to you and your spouse (if applicable), listed in the income section. All lines must be completed. If after you submit the application the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) determines more information is needed, you will receive a letter with the details describing what is needed. The program covers emergent and medically necessary services provided by the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC). The program will not cover medical bills you may have with other providers; please contact them directly to see what financial assistance programs they may have to offer.

Section One: Patient Information
Please complete all of the below information regarding demographics and insurance information. All lines be completed.

Account Number: _____ Date(s) of Service: _____

Name:_____

Last Name First Name Middle Name

Address: _____ City: _____

Number and Street

State Of Residence: _____ Zip Code:_____ Social Security Number: ____/___/____ Date of Birth:___/___/__

Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Phone: (____) _____ Other Phone: (____)_____

Are you a legal resident of the United States? ☐ Yes ☐ No ,

Name of Employer: _____ ☐ Patient ☐ Spouse ☐ Other

Name of Employer: _____ ☐ Patient ☐ Spouse ☐ Other

Did you have health insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ☐ Yes ☐ No

Name of Insurance: _____ Effective date of insurance: ____/_____/____

Subscriber Name: _____ Subscriber ID: _____ Group Number: _____

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Section Two: Household
Please provide the below information for all immediate family members who live in your home.
-For these purposes family includes the patient's spouse, patient's children under 18 (natural or adoptive) who live in the home.
-If the child(ren) are over the age of 18 and claimed on your current year taxes, child(ren) can be listed. Taxes must be included to show proof.

Family Member Name(s) Date of Birth Relationship to Patient

_____

_____

_____

_____

_____

Section Three: Income
Provide any below proof of income that applies for yourself, your spouse and all other family members

Income Source	Current Monthly Gross Income – Patient	Current Monthly Gross Income – Spouse/Other	Total Monthly Family Income	Proof of income (for below applicable sources)
Wages	$	$	$	Recent pay stub(s) showing at least 4 weeks' income and pay stub(s) showing full year to date income, or signed income verification letter from employer(s) documenting this information
Self-employment	$	$	$	Copy of last year's personal and business tax return including all schedules.
Child Support or Alimony	$	$	$	Copy of current court documentation, printed confirmation from Friend of Court, or check copies/bank statement documenting year to date income.
Social Security/Pensions	$	$	$	Copy of benefit award letter.
Dividends Interest, Rental Income	$	$	$	Dividend/Interest Statement, rental income statement or copy of last year's tax return showing dividend, interest or rental income
Unemployment, Worker's Comp	$	$	$	Year to date unemployment benefits documented with full years' pay stub(s) or a print out from the state website showing year to date income or denial letter showing ineligibility, Worker's Comp benefit letter showing year to date income
Veterans Benefits	$	$	$	Veterans benefits Letter
Other Income	$	$	$	Bank Statement or documentation showing any other income (education-based income, misc, income, etc)
Total	$	$	$	

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If no income, please briefly describe how basic living needs are being met and who is providing the support.

Section Four: Assets		
Please list all assets that apply for yourself, your spouse and all other family members.		
Asset Type	Current Balance for Patient	Current Balance for Spouse/Other
Bank Account – Savings	$	$
Bank Account - Checking	$	$
Stocks, Bonds, Funds	$	$
HAS/FSA Account	$	$
TOTAL	$	$

Section Five: Attestation
Please read the below section carefully and sign and date in the designated areas.

I understand the information I submit to the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) will be verified. I give permission to the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) to access my credit report if needed. I also understand that the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) may ask for more information, for example proof of assets, bank statements, or a Medicaid denial letter if it is needed to decide eligibility. The application may be denied if I do not provide the requested documents. I will exhaust all other possible resources for payment of my services such as Medicaid, SSI or SSDI, etc. I will take any action reasonably necessary to obtain such assistance and will assign or pay to WMCC the full amount recovered.

I understand that if I am accepted as a recipient of uncompensated service, the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) may release my name to other health care providers indicating I was a recipient of uncompensated services.

I authorize a representative of the West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) to obtain personal, financial or medical information from any source deemed necessary to determine my eligibility for uncompensated services. I authorize West Michigan Cancer Center Radiation & Surgical Specialties (WMCC) to apply for additional funding on my behalf as it becomes available. I may revoke this at any time by contacting the financial counseling department.

I have carefully read this application and all of this information I have provided is true.

Signature of Financially Responsible Party	Date	Relationship to Patient (if not self)
Signature of Spouse	Date	