A Patient Information: *Please complete this section about the patient receiving care*

Patient Name: _____ DOB: _____

B Patient or Responsible Party (Guarantor): *Please complete this section about the person responsible for the medical bill*

Street Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____ County: _____

Employer: _____

☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Not Currently Working

Family Size: _____

Family Member Name	DOB (Used to match to family member to Sparrow medical record)	Does this family member earn income?

*attach another sheet if needed for additional household members

C Qualifying Income

Please list any Family member (s) who earn income through employment.

(attach another sheet if needed)

Household Member Name	Relationship to Applicant	Monthly Gross Income (before deduction)
		$
		$
		$
	Total Monthly Gross Income	$

Please list any Family member (s) who earn income through employment.

(attach another sheet if needed)

Household Member Name	Relationship to Applicant	Monthly Gross Income (before deduction)
		$
		$
		$
	Total Monthly Gross Income	$

Please document and provide proof of non-wage income received by household members who meet the definition of family in the Financial Assistance Policy.

Other Qualifying Income	**Amount**	**Specify if Monthly or Yearly Amount**
Income from Business or Self-Employment	$	
Unemployment Compensation	$	
Workers' Compensation	$	
Social Security	$	
Supplemental Security Income	$	
Veterans' Payment	$	
Survivor Benefits	$	
Pension or Retirement Income	$	
Interest, Dividend, or Royalty Income	$	
Income from Rental Properties	$	
Income from Estates and Trust	$	
Child Support	$	
Assistance from outside the household	$	

D Authorization

I hereby authorize the release of the information contained in this application to Sparrow Health System for the determination of my eligibility status for financial assistance in accordance with Sparrow policies and procedures. All information regarding family size and income documentation provided by me in this application is true, accurate and complete as shown. If it is determined at any time the information I provided was false or inaccurate, all financial assistance will be reversed, and I will accept responsibility for full and immediate payment of any, and all outstanding balances. I also agree to accept payment responsibility for any amount due after any partial financial assistance discounts.

Print Name: _____

Signature: _____ Date: _____

Please provide proof of income with your application:

- If employed, three (3) recent pay stubs
- Social security, pension, or annuity statement
- Previous year's tax return, include Schedules related to business income/self-employment
- Documentation of non-wage income
- If no income, please complete Basic Needs Verification Form