MSU HEALTHTEAM FINANCIAL ASSISTANCE BLG 1—A

Patient Name: _____ Date: _____

Dates of Service: _____ Balance Due:_____

Responsible Party/Guarantor Information:

Name:_____

Social Security Number: _____ Relationship: _____

Address: _____City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Number of Dependents: _____ Ages of Dependents: _____

Dependents Living w/Responsible Party: _____ Employment Status: _____

Employer: _____ Phone Number: (____)_____ Years: _____

ANNUAL HOUSEHOLD INCOME:

Gross Salary	$_____
Interest Income	_____
Alimony	_____
Child Support	_____
Social Security Benefits	_____
Pension	_____
General Assistance	_____
Unemployment	_____
Disability/Workers Comp	_____
Other	_____
Total Income	$_____

For Internal Use Only:

Information Verified: Approved ☐

Denied ☐

If Approved—Discount Percentage:

General Medicine _____ Mental Health _____

Expiration Date: _____

If Denied—Reason for Denial:

_____

_____

_____

Patient Accounts Rep/Reviewers Initials

I hereby acknowledge that the information herein is correct to the best of my knowledge. I authorize Michigan State University to verify any information contained in this document, for the sole purpose of assessing financial need.

_____ _____

Signature of Responsible Party/Guarantor Date

_____ _____

Signature Patient Accounts Supervisor/Designee Date

MSU HEALTHTEAM
FINANCIAL HARDSHIP POLICY
INCOME GUIDELINES 2019

	100% of Poverty Level	133% of Poverty Level	150% of Poverty Level	185% of Poverty Level
	ANNUAL INCOME WITH CORRESPONDING WRITE-OFF PERCENTAGE			
FAMILY SIZE	**100%**	**75%**	**50%**	**25%**
1	12,490	16,612	18,735	23,107
2	16,910	22,490	25,365	31,284
3	21,330	28,369	31,995	39,461
4	25,750	34,248	38,625	47,638
5	30,170	40,126	45,255	55,815
6	34,590	46,005	51,885	63,992
7	39,010	51,883	58,515	72,169
8	43,430	57,762	65,145	80,346

Add $4,420 for each additional person

lrucker 7/2019