Dear Patient,

Lakeside Comprehensive Rehabilitation Inc. (LCR) believes that everyone should have access to and receive needed healthcare services regardless of his or her financial situation to pay for such services. LCR is committed to providing affordable rehabilitative care to the community. While health care is expensive, not everyone can pay for his or her care at the same level. This should not be the reason for them not to receive their care.

Therefore, we have created a Financial Assistance Program. This program features a Sliding Fee Scale that allows us to review your financial situation and determine your eligibility for a decrease in your rehabilitation out of pocket costs. We would like the opportunity to review your financial situation in order to determine your eligibility. The application must be submitted no later than 90 days after the first appointment rendered at LCR.

To begin the review process we will need you to complete the attached application and return it to our office along with the following items:

- All household income from the past 30 days (Wages, Social Security Income, Pension/Retirement, Disability Payments, Child Support, etc…)
- Bank Statement (Checking and Savings) from the last 30 days
- Previous year tax returns
- Letter of Support. (If you have no income and are living with someone else who is providing your room and board)

All applications are given serious consideration. We will provide you with a written response to your qualification in this program within 7 days of returning the forms to our office. If Assistance is found in your favor you will be given 30 days from the date the review was completed to pay any balance in full or set-up payment arrangements with the billing office if applicable. If the arrangements are not followed through or no payment is received on the account after 30 days the application will be considered void and any discounted fees will be reassessed to the account for payment. Please call us with any questions at (231) 873-3577.

Sincerely,

Erica Fenton
Director

APPLICATION FOR FINANCIAL ASSISTANCE

Application Date:_____

Patient Name:_____ **Date of Birth**____/___/____

Address:_____

City/State/Zip:_____

Home Telephone:_____**Cell Phone**:_____

Social Security Number:_____**Email Address:**_____

PLEASE PROVIDE THE FOLLOWING FOR ALL HOUSEHOLD MEMBERS:
(Attach Additional Sheet if Necessary)

Name	Date of Birth	Relationship to Patient	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have insurance? ___ No If Yes, Insurance Name:_____

ID # _____

Do you have Medicare? ___ No If Yes, Medicare ID # _____

Do you have Medicaid? ___ No If Yes, Medicaid ID# _____

Do you receive assistance with Medical Bills? ____No If Yes, Member IDs:_____
_____

(Examples: Access Health, Amish, Calhoun Health Dept., Church, Indian Reservation, Muskegon Care, Sliding Fee Scale, or Tencon)

Have you applied for Disability? ____No If Yes, When:_____

Is anyone in the household a Veteran?____No If Yes, Name:_____

EMPLOYMENT:

Person(s) employed in the household	Employer	Income before Taxes	Per (Circle One)
_____	_____	**$** _____	**Wk 2wks Mo**
_____	_____	**$** _____	**Wk 2wks Mo**
_____	_____	**$** _____	**Wk 2wks Mo**

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Is there a member of the household who became unemployed within the past 90 days?

_____No If Yes, Name:_____

Were health benefits received by this person? ____Yes ____No

MONTHLY HOUSEHOLD INCOME FROM OTHER SOURSES:

SOURCE	MONTHLY	ANNUALLY (for Office Use Only)
Child Support/Alimony	**$**	**$**
Federal Assistance Program Type:_____	**$**	**$**
Pension/IRA/403(b)/Annuity Cashout	**$**	**$**
Social Security/Social Security Disability	**$**	**$**
Unemployment or Workers Comp (Start Date_____End Date_____)	**$**	**$**
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	**$**	**$**

TOTAL MONTHLY GROSS INCOME **$_____** **$_____**
(Including income from employment) Monthly Annually (office use only)

ASSETS:

Cash on Hand $_____

Checking Account Balance Bank_____ $_____

Savings Account Balance Bank_____ $_____

Retirement Savings Account Bank_____ $_____

Investments or Other Securities $_____

Life Insurance Policy Cash Value $_____

Real Estate other than Primary Residence: Location:_____

Value: $_____

List below vehicles owned: (Include car, trucks, snowmobiles, RVs, motorcycles, etc.)

Type of Vehicle	Year	Value
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

TOTAL ASSETS: **$_____**

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MONTLY HOUSEHOLD LIABILITIES/EXPENCES

LIABILITY/EXPENCE	MONTHLY	PAST DUE BALANCE	ANNUALLY (for office use only)
Rent/Mortgage (Mortgage Balance:$_____)	**$**	**$**	**$**
Grocery Expenses	**$**	**$**	**$**
Child Care	**$**	**$**	**$**
Child Support/Alimony	**$**	**$**	**$**
Utilities: Gas $_____Electric $_____Water/Sewer $_____	**$**	**$**	**$**
Telephone: Mobile/Cell $_____ Home $_____	**$**	**$**	**$**
Medical Expenses (doctor visits, hospital expenses, other providers)	**$**	**$**	**$**
Medication Expenses (co-pays, cash pay, etc.)	**$**	**$**	**$**
Car Loan Payments Balance owed $_____	**$**	**$**	**$**
Transportation (Bus, Taxi)	**$**	**$**	**$**
Loan Payment Type_____ Balance $_____	**$**	**$**	**$**
Credit Card Payment(s) Total Balance(s) Owed $_____	**$**	**$**	**$**

TOTAL EXPENSES **$_____** **$_____** **$_____**

Monthly **Past Due** **Annually** (Office use only)

Are you under age 21? ___Yes ___No

Are you age 65 or older? ___Yes ___No

Are you pregnant now or have you been within the last 3 months? ___Yes ___No

Are you blind or disabled? ___Yes ___No

Are you a parent or close relative living with and acting as a parent for a child under the age of 18? ___Yes ___No

A) If you answered "Yes" to any of the above questions, you will need to include a Medicaid Determination Letter with this application. If you do not have one, you will need to apply for one.

B) If you have no income, you must complete a letter of support to be signed by the person (s) contributing to your housing.

CONTINUED ON NEXT PAGE

VERTIFICATION OF INCOME AND IDENTIFICATION

I hereby authorize LCR (Lakeside Comprehensive Rehabilitation Inc.) to release information on file to assist in the enrollment of various health and human service programs which I apply. I understand this information may include financial information, medical information and/or any other information contained in my file.

The U.S. Department of Health and Human Services (HHS) enforces the federal privacy regulations commonly know as the HIPAA Privacy Rule. HIPAA requires most doctors, nurses, pharmacies, hospitals, nursing homes and other health care providers to protect the privacy of your health information. Even though HIPAA requires health care providers to protect your privacy, providers are permitted, in most circumstances to communicate with the patient's family, friends, or others involved in their care or payment of care.

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I also understand that I will be liable for repayment of any services rendered at LCR if the above information is given under false pretenses.

SIGNATURE:_____ **DATE:**_____

SPOUSE'S SIGNATURE_____ **DATE:**_____
(if applicable)

OFFICE USE ONLY:

Application Reviewed by:_____ Date:_____

Is the Patient eligible for the Financial Assistance Program? _____Yes _____No

If Yes, Out of Pocket expenses will be reduced by _____% (Insured Patient)

The cost per visit is discounted to: Evaluation $_____ Daily Visit $_____ (Uninsured Patient)

Effective Date of Program:_____ Application Expires On:_____

If patient was not eligible for the Financial Assistance Program, provide a short reason why in the area provided below:

_____

_____

COMMENTS:_____

_____

REVIEWER SIGNATURE:_____ **DATE:**_____