HENRY FORD HEALTH Pharmacy

PHARMACY ADVANTAGE Specialty Pharmacy

PATIENT FINANCIAL ASSISTANCE PROGRAM

Dear Henry Ford Pharmacy Patient,

Thank you for choosing Henry Ford Health for your pharmacy needs. We recognize our commitment to providing accessible and affordable medications to all patients. Henry Ford Health's patient financial assistance programs are available to help eligible patients with the cost of their prescriptions filled at Henry Ford Pharmacy locations, including Pharmacy Advantage. To be eligible, you must be a Henry Ford Health patient under the care of Henry Ford Physicians prescribing from Henry Ford Health locations. You may be eligible for help with the self-pay portion of your bill that remains after your pharmacy insurance has paid its portion. **Do not terminate or let your pharmacy insurance lapse while participating in this program. If you do, your patient financial assistance may be terminated.**

To apply for this program and determine your eligibility, please complete the following steps:

1. If you are uninsured, please contact the Department of Human Services to apply for Medicaid/Healthy Michigan Plan. You must apply to be considered for any discounts beyond the Standard Uninsured Discount. **Michigan Health Care Helpline (855) 789-5610**

2. **To apply to the program, complete and sign the attached application. Also provide copies of the following:**

   - **Past two months of detailed bank statements (Checking & Savings)**

   AND

   - **Also, ONE of the following:**
     - **If employed:** Two most recent pay stubs
     - **If not employed:**
       - Most recent federal tax return
       - Official statement of disability or unemployment income
       - If you receive Social Security, disability, or unemployment benefits, please provide a copy of your monthly benefit statement.

*If you cannot provide any of the requested proof of income, please submit a letter of support. This letter should be from a family member, friend, or organization that can verify how your living expenses are being covered.

3. **Return application and all requested documents to:**

Henry Ford Pharmacy
Patient Financial Assistance Programs
30100 Telegraph Road, Suite 200
Bingham Farms, MI 48025
Email: PharmacyPFAP@hfhs.org
Fax: (248) 642-6094

A letter will be sent to you once a decision is made regarding your eligibility for financial assistance. If you need help completing the application or have questions, please call (248) 723-0014.

Applications are reviewed without discrimination, including ability to pay for services. All financial and personal information will be used only in the determination of eligibility for financial support. We are committed to maintaining and protecting your privacy regarding this information. Applications will be destroyed one year after the review date.

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Pharmacy

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A Hospital or Clinic Location: *Please select the location(s) where the patient received care*

☐ Henry Ford Hospital ☐ HF Kingswood Hospital ☐ HF Macomb Hospitals
☐ HF Medical Centers ☐ HF West Bloomfield Hospital ☐ HF Wyandotte Hospital or
☐ HF Allegiance Health ☐ HF Health Center Brownstown
☐ Other (Please specify:_____)

B Patient Information: *Please complete this section about the patient who received* care

Patient Name: _____ Date of Birth: _____
Social Security Number: _____ MRN: _____

Street Address: _____ Telephone: _____
City: _____ State: _____ Zip: _____ County: _____
Employer: _____ ☐ Full-time ☐ Part-time Work Phone: _____

C Health Insurance Eligibility Verification

1. Are you eligible for Medicare? 1a. Medicare Part A 1b. Medicare Part B	 ☐ No ☐ Yes ☐ No ☐ Yes	5. Does your employer or spouse's employer offer group health insurance?	☐ No ☐ Yes
2. Are you eligible for Medicaid?	☐ No ☐ Yes	6. Did you have coverage in the past 3-6 months through an employer?	☐ No ☐ Yes
3. Are you applying for financial assistance for services related to: 3a. Motor Vehicle Accident (MVA) 3b. Crime Victim 3c. Workers' Compensation 3d. Other Injury (e.g., Slip and Fall)	 ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes	7. Are you eligible to apply for insurance through the Health Insurance Exchange?	☐ No ☐ Yes
4. Do you have any other health insurance?	☐ No ☐ Yes	8. Are you a U.S. citizen or legal resident?	☐ No ☐ Yes
4a. If yes, please specify the insurance company:			

D Household Members & Household Employment Income

How many people are in your household (Including self)? _____

Please list any household member who earns an income: (attach an additional sheet if necessary)

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

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E Household Other Income (Non Employment)

Other Income Sources	Amount per Month
Child Support	**$**
Foster Care, Township Trustee, Church Income, etc.	**$**
Pension, Social Security, Social Security Disability	**$**
Rental Property	**$**
Annuities, Interest, Retirement Distribution	**$**
Unemployment or Worker's Compensation	**$**
Other *(Please specify)*	**$**
Total Other Income Sources	**$**

F Household Assets

Type of Asset	Total
Cash on Hand	**$**
Savings Account	**$**
Checking Account	**$**
Health/Medical Savings Account	**$**
Liquid Assets (e.g., Stocks, Bonds, IRA, Certificates of Deposit)	**$**
Total Assets	**$**

G Authorization

I hereby authorize the release of the information contained in this application to Henry Ford Health (HFH) for the determination of my eligibility status for financial assistance in accordance with HFH policies and procedures. I authorize HFH to verify this information as necessary, which may include but is not limited to, obtaining a credit bureau report, verifying employment and/or income, and obtaining appropriate supporting documents. All information 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 all outstanding balances. I also agree to accept payment responsibility for any amount due after any partial financial assistance discounts.

Print Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Please verify that you have completed the following prior to returning your application:

☐ Completed all pages of application	☐ Included proof of income or letter of support	☐ Last two months of recent bank statements: checking/savings
☐ Signed and dated application	☐ Included copies of medical/pharmacy insurance cards, if you have coverage	☐ Included a copy of the Medicaid denial letter, if you applied and were denied