Financial Assistance Application

All information submitted concerning annual income, family size and assets is subject to verification by Spectrum Health. If the information submitted is determined to be false, this application will be rejected. This application is for Tamarac dues financial assistance.

Contact Information

Application is for: Individual Family

Applicant legal name: ___________________________________ Date of birth: _____________________

Street address: ____ City, Zip: ________________________

Phone: __________________________ Email: ____

Are you currently employed? Yes No If unemployed, how long:_______________________________

Family members in household: _______________________

Total annual household income: ______________________

Applicant

Most recent employer: ________________________

Date hired: _______ Last date worked: ________

Annual salary: ___________ or

Hourly wage: _____ Average hours per week: ___

Partner

Most recent employer: ________________________

Date hired: _______ Last date worked: ________

Annual salary: ___________ or

Hourly wage: _____ Average hours per week: ___

Additional Members Living in Household

Name	Date of Birth	Relationship	Applying*	
____________________	____________________	____________________	Yes*	No
____________________	____________________	____________________	Yes*	No
____________________	____________________	____________________	Yes*	No
____________________	____________________	____________________	Yes*	No

* Additional application fee must be paid for each applicant for consideration in the program.

Other Sources of Monthly Income (list amounts)

Please submit a copy of your most recent tax return, payroll stubs and other documents listed in the cover letter.

Monthly Income	Applicant	Partner	Dependants/Other
Commission, bonus and/or tips	$ ____________	$ ____________	$ ____________
Social Security	$ ____________	$ ____________	$ ____________
Disability	$ ____________	$ ____________	$ ____________
Public assistance/food stamps	$ ____________	$ ____________	$ ____________
Unemployment benefits	$ ____________	$ ____________	$ ____________
Student loans and grants	$ ____________	$ ____________	$ ____________
Workman's Compensation	$ ____________	$ ____________	$ ____________
Child support	$ ____________	$ ____________	$ ____________
Rental income	$ ____________	$ ____________	$ ____________
Investments	$ ____________	$ ____________	$ ____________
Other income (pensions, benefits, alimony, etc.)	$ ____________	$ ____________	$ ____________

Assets

Please list all account balances at all banks. Use “other” for additional checking, savings, HSA or other accounts.

Account Type	Balance	Bank Name
Checking	_______________	____
Savings	_______________	____
Other: ______________________	_______________	____

Transporation

Make and Model	Monthly Payment	Balance
Primary vehicle ___________________________________	$ _____________	$ _____________
Secondary vehicle _________________________________	$ _____________	$ _____________
Motorcycle _______________________________________	$ _____________	$ _____________
Other vehicle(s)*__________________________________	$ _____________	$ _____________

* Include snowmobiles, boats, trailer, motor home, ATV and any other vehivles applicant owns and has a payment for.

Household Expenses

List applicable monthly payments. Only property taxes are accounted as an annual amount. Please include both summer and winter taxes.

House payment	$ ____________/month	Rent	$ ____________/month
Property taxes (annual)	$ ____________/year	Phones (including mobile)	$ ____________/month
Childcare/child support	$ ____________/month	Medications	$ ____________/month
Health insurance	$ ____________/month	Cable/DISH/Internt	$ ____________/month
Life insurance	$ ____________/month	Trash removal	$ ____________/month
Electric	$ ____________/month	Groceries	$ ____________/month
Gas/propane	$ ____________/month	Student loan/tuition payment	$ ____________/month
Water	$ ____________/month	Other: ___________________	$ ____________/month

Credit Card and Loan Payments

Name of lender/card	Monthly Payment	Balance
____	$ _____________	$ _____________
____	$ _____________	$ _____________
____	$ _____________	$ _____________

Personal Statement

I would like to join Tamarac because:____

____

____

____

____

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Note: Please use only the space provided and do NOT submit additional personal statement or phsycian referrals. Additional documents will not be considered.

Continue application on page 3.

I affirm to the best of my knowledge that this information is true and accurate. Prior to seeking financial assistance, I have pursued all reasonable forms of third party payment. If accepted, I agree to follow program rules in addition to facility membership rules, regulations, and guidelines.

Signature ____ Date ________________

For questions, call (guardian/payee/other) __________________ at ______________. I am available ____________

Disclosure of Personal Health Information
Spectrum Health is commited to protecting the confidentiality of your personal and health information. Spectum Health will not disclose your information without your written authorization. Your information will be used for Financial Assistance Criteria. Spectrum Health may use and disclose your health information for the seamless delivery of services and to document anonymous program outcomes at Tamarac, a member of Spectrum Health. For example, we may use your personal information to interpret your need for participation in our program and to contact you regarding program acceptance or discharge.

Office Use Only
Application received on ______/______/______/ by (representative name) _________________________________