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(269) 349-2266, www.gsm-kec.com

Today's Date:

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Dear Financial Services of Gastroenterology of SW MI,

I understand that I have an outstanding balance of \$_____ for medical services with Digestive Health Associates of Southwest Michigan, P.C. DBA: Gastroenterology of Southwest Michigan. I also understand that the office is offering a payment agreement with me at this time, but currently, my financial situation is such that I cannot afford to pay the balance on the account. I attest that I meet the poverty guidelines as outlined below. Therefore, I am asking for a payment consideration at this time.

I affirm under the penalties of perjury that the statements contained above are true.

Federal Poverty Guidelines for 2012

Persons in family/household	Poverty guideline
1	\$11,170
2	\$15,130
3	\$19,090
4	\$23,050
5	\$27,010
6	\$30,970
7	\$34,930
8	\$38,890

For families/households with more than 8 persons, add \$3,960 for each additional person.

Patient Name _____ Patient Date of Birth: _____

Please sign and return this document to the address listed above with the following information:

_____ Two months of paycheck stubs

_____ Two months of bank statements

Yes or No Have you received assistance from Bronson or Borgess Financial department(s)? (please circle one)

Comments concerning your financial situation:

Further financial assistance: Bronson - 341-6120 / 341-7761

Borgess - 226-7370

Name of Legal Representative:

(printed)

Legal Relationship to patient:

(printed)

Signature of Patient or Legal Representative:

(Signature)

____/____/____
Date