Request For One-Time 2017 MDHIP Financial Assistance

Print your full name ____
Your address ____
Your phone number ______________ Date of Birth ______________
Name of your 2017 health insurance company ___________________________
Your 2017 health insurance Member/Subscriber ID number _________________
2017 Group Number (if your insurance company is Blue Care) ____________
Monthly cost of your 2017 health insurance is $__________ per month
Is your 2017 health plan Silver? _____ Did you have a Silver plan in 2016?_____
Number of people being insured? ____
Are you married? ____
How many children live with you or are dependent on you? _____
Number of other relatives living with you? _____
Does a boyfriend or girlfriend live with you? _____
Do you rent____, own home___, have mortgage____, live in another's home____?
What is your expected 2017 gross income for the year? $__________

Answer the questions below that apply to you:
What is your spouse's expected 2017 gross income for the year? $_________
What is the expected combined 2017 yearly gross income of all children living with you or who are dependent on you? $ __________
Expected 2017 gross income of other relatives living with you? $___________
Your live-in boyfriend/girlfriend's 2017 expected gross income? $___________
Expected 2017 child support payments you will receive? $________________
If disabled, what is your Medicare start date? ______________

I, (print your name)___________________________________, by signing below, swear under penalty of perjury that the information that I have provided on this form is all true.

_____________________________________ _________________
Signature Date

Mail to: MDHIP
PO Box 32
Troy, MI 48099