SHERIDAN COMMUNITY HOSPITAL

Application for Patient Financial Assistance

Guarantor's Last Name	First Name	MI

Address - Street	City/State	Zip Code

Social Security No.	Home Phone	Employer Name & Phone Number

List names of household members and……..Dates of birth

_____ _____
_____ _____
_____ _____
_____ _____

Total number of dependents claimed on your income taxes --in box below

☐

The following information must be provided before a determination of eligibility can be made.

Please provide the proof of household income information that applies below:

☐ ⇒ Employment: Copies of check stubs for the last three months.

☐ ⇒ Last year's income tax return.

☐ ⇒ Unemployment benefits: Check voucher and copy of unemployment card.

☐ ⇒ Social Security benefits: Copy of grant letter or bank statement if automatic deposits are made.

☐ ⇒ Workmen's Compensation: Proof of amount received.

☐ ⇒ Pension: Proof of amount received.

☐ ⇒ ADC-Welfare: Proof of amount received; copy of grant letter if possible.

☐ ⇒ GA-Welfare: Proof of amount received; copy of grant letter if possible.

☐ ⇒ Child Support or Child Care Income: Proof of amount received.

☐ ⇒ Other source of income: _____

☐ ⇒ If you have **NO INCOME**, please provide a letter from the person(s) who support you which explains why they are providing your support.

Please provide a copy of your Medicaid Denial (it must have been within the last 90 days, if not go to www.mibridges.michigan.gov/access to apply)

Cosmetic and nonessential services will not be considered.

I certify that the above information is true and accurate to the best of my knowledge. I understand that in order to be in compliance with the eligibility conditions established by Sheridan Community Hospital, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. Failure to return the required income information or work with any other agents assigned by Sheridan Community Hospital in an attempt to obtain third party coverage will be cause for denial of this application for assistance. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request _____ Applicant's Signature _____

I understand that the information which I submit concerning my annual income, family size and assets, is subject to verification by Sheridan Community Hospital. I also understand any false information may result in a rejection of this application and the outstanding balance is due and payable immediately.

Patient Name _____ **Spouse/Partner Name** _____

Date of birth _____ Date of Birth _____

Social Security Number _____ Social Security Number_____

Address _____ Address _____

Phone Number _____ Phone Number _____

Most Recent Employer_____ **Most recent employer** _____

Date of Hire_____ Last day worked_____ Date of Hire_____ Last day worked_____

Salary $_____/year_____ Salary $_____/year_____

Hourly wage $_____ Average hours per week___ Hourly wage $_____Average hours per week_____

Other sources of monthly income (List amounts) **Other sources of monthly income (List amounts)**

Social Security $ _____ Pension $_____ Social Security $_____ Pension $_____

Alimony $_____ Unemployment $ _____ Alimony $_____ Unemployment $_____

Disability $_____ Commission $_____ Disability$_____ Commission $_____

Tips $_____ Child Support $_____ Tips $_____ Child Support $_____

Rental Income $_____ Investment $_____ Rental Income $_____ Investments $_____

Public Assist $_____ Childcare $_____ Public Assist $_____ Childcare $ _____

Workman's compensation $_____ Workman's compensation $_____

Other_____ $_____ Other _____ $_____

TOTALNET INCOME $_____ **TOTALNET INCOME** $_____

List dependents claimed in Income Tax return (other than self and spouse)

Dependent Name **Date of Birth** **Relationship to Responsible Party (spouse, child, etc.)**

_____

_____

ASSETS

Checking account Balance $_____ Name of Bank _____

Savings account Balance $_____ Name of Bank _____

Value of Stocks $_____Value of bonds $_____ Value of Life Insurance $_____

Value of mutual funds $_____Value of IRA $_____Value of Annuities $_____

Assessed Value of Home $_____ Assed Value of home #2 $_____ Other Property $_____

TRANSPORTATION

Vehicle #1 year/model _____/_____ Payment $_____ Gas $_____/mo. Insurance $_____/mo.

Vehicle #2 year/model _____/_____ Payment $_____Gas $_____/mo. Insurance $_____/mo.

Motorcycle year/model _____/_____ Payment $_____ Gas $_____/mo. Insurance $_____/mo.

Boat year and model _____/_____ Payment $_____Gas $_____/mo. Insurance $_____/mo.

Snowmobile year/model _____/_____ Payment $_____Gas $_____/mo. Insurance $_____/mo.

Trailers/Motor homes _____/_____ Payment $ _____ Gas $_____/mo. Insurance $_____/mo.

RV, ATV, SUV _____/_____ Payment $_____Gas $_____/mo. Insurance $ _____/mo.

Monthly fare: Bus $_____/mo. Taxi $_____/mo.

HOUSEHOLD EXPENSES

House payment $_____ Rent $_____ House/Rental Insurance $_____

Property taxes (Year) $_____ Gas/Propane $_____ Electric $_____

Water $_____ Phone $_____ Cell Phone $_____

Cable/Dish/Internet $_____ Trash Removal $_____ Groceries $_____

Childcare/Child support $_____ Clothing $_____ Tuition $_____

Health Insurance $_____ Life Insurance $_____ Other _____ $_____

CREDIT CARDS/LOAN PAYMENTS

Name of lender/card _____ Payment $_____ Balance $_____

Name of lender/card_____ Payment $_____ Balance $_____

OUT OF POCKET MEDICAL AND PAHARMACY (SEND proof of your expense)

Name of provider or prescription _____ Payment $ _____ Balance $ _____

Name of provider or prescription _____ Payments $ _____ Balance $ _____

Were you denied by the State for Medicaid Assistance due to excess assets? Yes _____ NO _____

(Please provide copy of Denial.)

If yes, please explain these assets

_____

_____

I affirm to the best of my knowledge that the above information is true and accurate. I will provide the required documents for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital and professional charges.

In an attempt to qualify for assistance failure to comply with the policy for financial assistance will result in denial. This application is subject to verification and if found false will result in denial of acceptance into program and reinstatement of original charges will fall under normal collection efforts.

Signature of person making request_____Date_____