SHERIDAN CARE AND
SHERIDAN COMMUNITY HOSPITAL

Sheridan Care and Sheridan Community Hospital offer financial assistance to help those who need help paying for their medical care provided at our facilities. Along with filling out this application, our process requires the patient to share with us their most current financial documentation and possibly require the patient to fill out a Medicaid application to best determine the amount of financial assistance the patient is eligible for.

Patient Information

First Name _____M.I._____

Last Name _____

Date of Birth _____Age_____

Home Address_____

City and State_____

Zip _____

Mailing Address_____

City and State_____

Zip _____

Phone # _____-_____-_____

Social Security # _____-_____-_____

Do you currently have insurance? (check one)

- ☐ Yes
- ☐ No

Marital Status (check one)

- ☐ Single
- ☐ Married
- ☐ Divorced/ Separated
- ☐ Widowed

Household Size _____

Please include the name and date of birth of each member

_____

_____

_____

_____

_____

Have you applied for any financial assistance at Sheridan Care or Sheridan Community Hospital in the past year? (check one)

- ☐ Yes
- ☐ No

Which financial assistance programs are you interested in applying for? (Check each)

- ☐ Sheridan Care (discount based on poverty level at Sheridan Care)
- ☐ Sheridan Community Hospital (discount based on poverty level at Sheridan Community Hospital)
- ☐ Financial Hardship (changes in income, making it difficult to pay your current bills)

Depending on which program you are applying for and your poverty level, it is possible that you may be required to fill out an application for Medicaid. This application can be found at newmibridges.michigan.gov. If you need assistance filling out this application please contact the financial assistance coordinator by phone at **989-291-6264** or email by email at fa@sheridanhospital.com, you may also come in Monday-Friday from 7:00am-3:30pm.

To comply with federal regulations and in order for Sheridan Care and Sheridan Community Hospital to help patients financially, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence.

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Income Source *(only fill out and provide documentation where applicable)*	**Patient:** Monthly Gross Income	**Spouse or Guarantor:** Monthly Gross income	**Proof of Income**- Required for each source. *If no income, please provide a letter from the person(s) who support you which explains why they are providing your support.*
Wages	$	$	Check stub(s) or W2 showing at least the last four weeks of income ***and*** last year's tax return.
Self- Employment	$	$	Copy of last year's personal ***and*** business tax return.
Child Support and/or Alimony	$	$	Copy of current court documentation, printed confirmation from friend of the court, or check copies/bank statement.
Social Security	$	$	Copy of benefit award letter, check stub(s), or bank statements showing deposit.
Retirement Pension	$	$	Copy of benefit award letter, check stub(s), or bank statements showing deposit.
Dividends, Interest, and/or Rental Income	$	$	Dividend/Interest statement, rental income statement, or copy of last year's tax return showing dividend, interest or rental income.
Unemployment and/or Workman's Comp	$	$	Printout or letter from the state website showing year to date income or a denial letter showing ineligibility; Workers' Compensation benefit letter showing year to date income.
Veterans Benefits	$	$	Veteran's benefits letter.
Other Income	$	$	Bank statement or documentation showing any other income
Total(s)	$	$	**= $**

Current Checking Account Balance $_____ Current Savings Account Balance $ _____

Please also provide current months statement for each open bank account

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for financial assistance programs at Sheridan Care and Sheridan Community Hospital. I further agree to inform Sheridan Care/Sheridan Community Hospitals Financial Assistance Coordinator if there are any significant change in my income. 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. I hereby acknowledge that I read the foregoing disclosure and understand it.

Applicants Signature _____Date _____