Financial Assistance Program Policy Plain Language Summary

Here at Sheridan Community Hospital we care about you and your family needs. Providing care for those with limited or no ability to pay is important to us. Sheridan Community Hospital, in accordance with Section 501(r) of the Patient Protection and Affordable Care Act of 2010 has established a Financial Assistance Policy.

Eligibility Requirements

- Any patient can apply for financial assistance, if they apply within 240 days or 8 months from when the post discharge billing statement was sent to the patient and provide the required documentation.
- Patients can be eligible for financial assistance if they are uninsured or underinsured.

How to apply?

- Any patient can apply for financial assistance. An application can be found online at https://www.sheridanhospital.com/payments.asp along with the financial assistance policy and financial hardship application.
- An application can also be requested at the time of service from Emergency Room Registration or Southwest Registration staff at Sheridan Community Hospital. Assistance can also be requested by calling the Financial Assistance Coordinator at 989-291-6264.

Eligibility

- Patients and/or responsible parties with balances owed to Sheridan Community Hospital may be eligible for financial assistance. Financial assistance eligibility is based on the Federal Poverty level that is determined by family size and income.
    - The Federal Poverty Income Guidelines to determine eligibility can be found at https://aspe.hhs.gov/poverty-guidelines.
- Patients with Medicaid qualifiers must also complete an application for Medicaid that can be found at https://newmibridges.michigan.gov/s/isd-landing-page?language=en_US

Additional Information

- A patient determined to be eligible for financial assistance may not be charged more than amounts generally billed for emergency or other medically necessary care.
- Sheridan Community Hospital will provide, without discrimination, emergency and other medically necessary care to patients regardless of their eligibility for financial assistance or government assistance.
- Sheridan Community Hospital provides aids and services for people with disabilities to communicate effectively and provides free language services to people whose primary language is not English.
- Sheridan Community Hospitals Financial Assistance Policy complies with Section 501(r) of the Patient Protection and Affordable Care Act of 2010 and State of Michigan Public Act 107 which created financial assistance stipulations for charitable hospital organizations operating as a 501(c)(3) corporation.

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Required documentation to turn in with completed application

- ☐ Completed application for Medicaid with attached acceptance or denial
  - You can apply online at https://newmibridges.michigan.gov or at Sheridan Community Hospital, by contacting the Financial Assistance Coordinator at 989-291-6264, or at the Department of Health and Human Services 989-831- 8400.
- ☐ Current Banks Statements: Showing all transactions for the past month and current balances
- ☐ Employment: Copies of check stubs for the last three months ***OR*** last paycheck if year-to-date income is reported
- ☐ Last year's income tax return, if taxes were filed
- ☐ Unemployment benefits: Check voucher ***OR*** bank statement if automatic deposits are made
- ☐ Social Security Benefits: Copy of grant letter
- ☐ Pension Benefits: Copy of grant letter
- ☐ Workmen's Compensation: Copy of grant letter ***OR*** bank statement if automatic deposits are made
- ☐ Child Support Income: Copy of grant letter ***OR*** bank statement if automatic deposits are made
- ☐ Other sources of income: Cash assistance, etc.

You must provide this information ***for you and your spouse***, with the exception of the Medicaid application that is only required for the patient, but it is strongly encouraged for both to apply.

You may deliver or mail your application ***and*** all materials to:

Financial Assistance Coordinator
Sheridan Community Hospital
301 North Main Street, P.O. 279
Sheridan, MI 48884

If you need assistance in completing the application or if you have any questions, please contact the Financial Assistance Coordinator.

Financial Assistance Coordinator
Sheridan Community Hospital
Office: 989-291-6264
fa@sheridanhospital.com

Sheridan Community Hospital offers 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.

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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 Community Hospital in the past year? (check one)

- ☐ Yes
- ☐ No

Current Checking Account Balance $_____Current Savings Account Balance $_____

Please also provide current statement for each open bank account showing total balance and all transactions.

Depending on 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.

To comply with federal regulations, it is necessary for us to ask these questions, answers will be kept on file and in strict confidence.

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 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),
Retirement Pension	$	$	Copy of benefit award letter, check stub(s),
Dividends, Interest, and/or Rental Income	$	$	Dividend/Interest statement, rental income statement, copy of last year's tax return showing dividend, interest or rental income, ***or*** bank statement showing deposit
Unemployment and/or Workman's Comp	$	$	Printout or letter from the state website showing year to date income, a denial letter showing ineligibility ***or*** bank statement showing deposit
Veterans Benefits	$	$	Veteran's benefits letter ***or*** bank statement showing deposit
Other Income	$	$	Documentation showing any other income ***or*** bank statement showing deposit
Total(s)	= $	= $	Total monthly income $ Total yearly income $

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 Community Hospital. I further agree to inform 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 have read the foregoing disclosure and understand it.

Applicants Signature_____Date _____