Sheridan Care
303 N. Congress St. • P.O. Box 279 • Sheridan, MI 48884
Phone: 989.291.5077 • Fax: 989-291-5348 •
www.sheridanhospital.com

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

For Sheridan Community Hospital and Clinic to process your application, all sections must be completed. Along with your application, required documents may include:

- Proof of income for all income sources (previous year's tax return, last 2 pay stubs, and/or social security benefit letters, etc.)

Determination is based on household size and income

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information.

Applicant Name: _____
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State:_____ Zip Code:_____

Phone Number: _____ Email: _____

SECTION TWO: HOUSEHOLD MEMBERS and INCOME INFORMATION

Please provide the below information for all immediate family members who live in your home. For application purposes, Family is defined as the applicant, the applicant's spouse, and all of the applicant's children under 18 (natural or adoptive) who live in the applicant's home.

Name	Date of Birth	Relationship to Applicant	Total Gross Monthly Income (All Sources)
(Applicant)		self	

If additional space is required feel free to include on an additional page.

SECTION THREE: INSURANCE INFORMATION*

Please provide your health insurance/medical coverage information, if applicable.

Was your service related to a Worker's Compensation claim*? Yes / No

Was your service related to a motor vehicle accident*? Yes / No

Insurance Company Name: _____ Insurance Phone Number: _____

Group Number:_____ Member ID Number: _____

I certify that the above information is true and accurate to the best of my knowledge. I understand determination is based on household size and income. Financial assistance is not guaranteed. I understand that this application is made so that my eligibility for financial assistance can be determined based upon defined criteria.

Signature of Applicant:_____ Date:_____