Sheridan Care
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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:

- Request documentation for Proof of income
  - Previous year's tax return
  - Previous 30 day pay stubs or Social security benefit letters
  - Pension letters

Determination is based on household size and annual 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	

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. Sliding Fee Scale 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:_____