

APPLICATION FOR FINANCIAL ASSISTANCE

For Sheridan Community Hospital, Sheridan Care and its associated entities to process your Financial Assistance application, all sections of the application must be completed in full. Along with your completed application, the following documentation is required:

- Copy of a valid State Identification Card (front and back)
- Denial correspondence from any applicable state assistance programs for which you may qualify
- Proof of income for all household income sources:
 - Prior year's tax return (IRS Form 1040), and corresponding W2's or 1099's
 - Minimum of recent pay stubs for the last 30 days
 - Social Security Benefit Letter
 - Copies of all checking and/or savings accounts for a minimum of the previous 3 months
 - Copies of financial statements, 401K
 - Unemployment, Veteran's benefits, alimony, child support

Determination is based on household size and income. Failure to provide all required documentation may result in delays in processing, or denial of your application until the requested information is received.

SECTION ONE: APPLICANT INFORMATION

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

Applicant Name: _____
FIRST NAME M.I LAST NAME

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ 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, please include an additional page.

If there is no income, please explain how applicants are supporting themselves: _____

SECTION THREE: INSURANCE INFORMATION*

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

Do you have Medical/ Hospital Insurance? Yes / No

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Address: _____ Member ID/ Contract #: _____

Was your service related to a Worker's Compensation claim? Yes / No
 Was your service related to a motor vehicle accident? Yes / No
 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. I will apply and take any reasonable action needed to get assistance (Medicaid, Medicare, Insurance, etc.) to pay my Sheridan Community Hospital and associated entities charges. Financial assistance is a source of last resort. Any other liability or possible payer will be exhausted prior to awarding assistance. I understand that this application is made so that the hospital can see if I am eligible for financial assistance based upon defined criteria.

Signature of Applicant: _____ Date: _____