Schoolcraft Memorial Hospital
Community Care Application

	Patient Information	Guarantor Information (if different than pt.)
Patient Name	_____	_____
Relationship to Patient	_____	_____
Social Security #	_____	_____
Date of Birth	_____	_____
Home Phone #	_____	_____
Work Phone #	_____	_____
Cell Phone #	_____	_____
Address	_____	_____
City	_____	_____
State	_____	_____
Zip	_____	_____

Marital Status (check one):
Single_____ Married_____ Widowed_____ Separated_____ Divorced_____

Employment Status (check one):
Employed_____ Retired_____ Disabled_____ Unemployed_____ Student_____ Dependent____
Seasonal_____

Household Information:
Number of IRS Dependents _____
Number of Other Household Members (that are not dependents not including self) _____

Income Information: Please list your monthly income from all sources below.

	Patient (or Guarantor)	Other Household Member's Income	Total Household Income
Employment	_____	_____	_____
Pension	_____	_____	_____
Social Security	_____	_____	_____
Veterans Benefits	_____	_____	_____
Workers Compensation	_____	_____	_____
Unemployment	_____	_____	_____
Interest / Dividends	_____	_____	_____
Alimony or Support	_____	_____	_____
Health Savings Account	_____	_____	_____
Rental Property	_____	_____	_____
Other (please specify)	_____	_____	_____
Total Monthly Income	_____	_____	_____

Please attach a copy of the following:
1) Prior year's federal income tax return
2) Pay stubs for the past 2 months

Affirmation of Financial Disclosure

Omitting information or providing fraudulent information will be cause for permanent denial.
I, _____ certify that the above information is true and complete. I understand that the information provided on this form may be verified before approval for assistance may be granted. I further certify that I have made every attempt to pay for the care received.

_____ _____
Signature of Patient or Responsible Party Date

The patient/guarantor will be notified in writing within 10 days of the decision to approve or deny the application.

(For internal use only)
The applicant submitted all of the required information: Yes_____ No_____

The Community Care Program is: Approved_____ %_____ Denied_____
The Medically Indigent Discount is: Approved_____ %_____ Denied_____

If denied, reason for denial: _____
_____
_____

Date applicant was provided with a copy of determination: _____

_____ _____
Signature of person making eligibility determination Date