SCHOOLCRAFT MEMORIAL HOSPITAL

SLIDING FEE APPLICATION

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

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	_____	_____	_____
Income	_____	_____	_____
Workers Compensation	_____	_____	_____
Unemployment	_____	_____	_____
Interest / Dividends	_____	_____	_____
Alimony or Support	_____	_____	_____
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
3) Outside Medical Debt

Monthly Expenses Please list your monthly expenses below:

Rent/Mortgage	$_____
Utilities	$_____
Food	$_____
Phone/Pager	$_____
Auto Loan	$_____
Auto Insurance	$_____
Loans	$_____
Child Support	$_____
Alimony	$_____
Credit Cards (min payment)	$_____
Medical Debt	$_____
Other	$_____

Total Monthly Income	$_____	
Total Monthly Expenses	$_____	
Amount Available	$_____	x 12 = Annual_____

Affirmation of Financial Disclosure

Omitting information or providing fraudulent information will be cause for rejection of application. 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.

_____ _____

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.

Updated:

For Office Use Only	
Recommendation: __ Full Charity (Fully Indigent) __Partial Charity: _____% __ Medically Indigent __ Denied: Reason:_____	Reviewed/Approved by:_____ Date:_____