Scheurer Health

YOU HAVE 30 DAYS TO RETURN THIS APPLICATION TO:

SCHEURER HOSPITAL BUSINESS OFFICE 170 N. CASEVILLE ROAD, PIGEON, MI 48755

2020 REQUEST FOR FINANCIAL ASSISTANCE PROGRAM

Applicant Name _____ (IF APPLICANT IS UNDER 18 YOU MUST LIST A GUARANTOR)

Guarantor's Name _____ Spouse's Name_____

Social Security: _____ D.O.B._____ Social Security: _____ D.O.B._____

Employer_____ Employer_____

Circle One: Employed Unemployed Retired Disabled

Pay Day: Mo Tu We Th Fr Sa Su

Frequency: Weekly Bi-Weekly Monthly

Insurance: _____

Insurance Co-Pay $_____ Deductible $_____

Circle One: Employed Unemployed Retired Disabled

Pay Day: Mo Tu We Th Fr Sa Su

Frequency: Weekly Bi-Weekly Monthly

Insurance: _____

Insurance Co-Pay $_____ Deductible $_____

Number of Dependents in Household _____ (List Name & Age of each Dependent on separate sheet)

Home Address_____ City _____ State_____ Zip Code_____

Home Phone_____ Guarantor's Cell Phone_____ Spouse's Cell Phone_____

INSTALLMENT LOANS AND CREDIT CARDS

CREDITOR	MONTHLY PAYMENT	BALANCE OWED

HOUSEHOLD MONTHLY INCOME AND EXPENSES

INCOME ITEM	AMOUNT (MONTHLY)	EXPENSE ITEM	AMOUNT (MONTHLY)
Applicant/Guarantor Wages		Electric Bill	
Spouses Wages		Telephone	
Social Security Income		Water/Sewer/Trash	
Disability Income		Heat	
Unemployment/Worker's Comp		House Insurance	
Child Support/Alimony		Property Taxes	
Pension		Automobile Insurance	
Interest or Inheritance		Life Insurance	
Land Contract/Rental Income		Child Care	
Awards/Law Suits		Medical Ins Premium	
Food Stamps		Medications	
Veterans		Medical Expenses	
Rent/Mortgage		Child Support/Alimony	

Please attach any further details regarding your household income and expenses that may be pertinent to your application. You must submit the most current Federal Income Tax Returns and current proof of income with your application. It is your responsibility to report any changes in your status (married, new job, new insurance, etc). Failure to report such changes could result in loss of the financial assistance discount. I hereby affirm that the above information is correct to the best of my knowledge. I authorize Scheurer Hospital and its subsidiaries to verify any information for completeness and accuracy. I further authorize such information to be available to Scheurer Hospital and its affiliates. I understand that more information may be required from me to process this application. I understand that as a charitable organization, Scheurer Healthcare Network may provide me with discounted or free care.

_____ _____ _____ _____

APPLICANTS SIGNATURE DATE SPOUSE'S SIGNATURE DATE