



**You have 30 days to return this application to:  
Scheurer Hospital Business Office 170 N. Caseville Road, Pigeon, MI 48755**

## 2021 Request for Financial Assistance Program

**\*\* It is the policy of Scheuer Health to provide essential services regardless of the patient's ability to pay. Scheurer Health offers discounts based on family size and annual income.**

**\*\* Please complete the following information and return it to our Fiscal Services Department to determine if you or members of your family are eligible for a discount.**

**\*\* The discount will apply to all services received at Scheurer Health, but not those services or equipment purchased from outside, including reference laboratory testing, pharmacy, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.**

(Please print)

Applicant Name \_\_\_\_\_ (If Applicant is under 18 you must list a Guarantor)

Guarantor's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Number in Household \_\_\_\_\_ (including applicant) Please list spouse and dependents.

Name	Date of Birth	Name	Date of Birth

Name & Address of Health Insurance: \_\_\_\_\_

**HOUSEHOLD MONTHLY INCOME**

Monthly Income Item	Self	Other	Monthly Income Item	Self	Other
Applicant/Guarantor Gross Wages			Interest, Dividends, Royalties		
Social Security Income			Income from Rental Properties, Estates, & Trusts		
Disability Income			Assistance from Outside the Household		
Unemployment, Worker's Comp			Pension, Retirement Income		
Child Support, Alimony			Public Assistance		
Supplemental Security Income			Veteran's Payments		
			Other Miscellaneous Sources		

**You must submit your 2020 Federal Income Tax Return and current proof of income with your application.**

Please attach any further details regarding your household income that may be pertinent to 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 certify that the family size and income information shown above is correct. I authorize Scheurer Health and its subsidiaries to verify any information for completeness and accuracy. I further authorize such information to be available to Scheurer Health 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 Health may provide me with discounted or free care.

\_\_\_\_\_  
**Applicant/Guarantor Signature**

\_\_\_\_\_  
**Date**