Scheurer

Better Health. Better Life.

You have 30 days to return this application to:
SCHEURER HOSPITAL BUSINESS OFFICE
170 N. CASEVILLE RD., PIGEON, MI 48755

2019 Request for Financial Assistance Program

Patient Name(s) ______________________________

Guarantor's Name ______________________________ Spouse's Name ______________________________

Social Security # ______________ D.O.B. __________ Social Security # ______________ D.O.B. __________

Employer ______________________________ Employer ______________________________

Work Phone ______________________________ Work Phone ______________________________

Insurance ______________________________ Insurance ______________________________

Insurance CoPay __________ Deductible __________ Insurance Copay __________ Deductible __________

Home Address ______________________________ City ______________ State _____ Zip Code ______

Home Phone ______________ Guarantors Cell Phone ______________ Spouses Cell Phone ______________

Number of Dependents in Household __________ Name/Age of Dependents ______________________________

Please Check One:
- ☐ Actively Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Disabled

Pay Days (Check Day & Frequency)
☐M ☐T ☐W ☐TH ☐F ☐Sat ☐Sun
☐Weekly ☐Bi-Weekly ☐Semi-Monthly ☐Monthly

SAVINGS (CD, Money Market, IRA) **Checking and Credit Union Accounts**

Bank Name	City	Type of Account	Account Number	Balance

Do you own your home? ☐Yes ☐No If Yes, list below.

Do you own any other property? Vehicles, Recreational Vehicles, Other Real Estate? ☐Yes ☐No If Yes, list below

ASSETS

Asset - Home, Vehicle, Etc.	Market Value	Loan Amount Outstanding

See Reverse Side

HOUSEHOLD MONTHLY INCOME AND EXPENSES

Income Item	Amount (Monthly)	Expense Item	Amount (Monthly)
Applicants Wages		Rent/Mortgage	
Spouses Wages		Electric	
Social Security Income		Telephone	
Disability Income		Water	
Unemployment		Trash	
Worker's Comp		Heat	
Child Support		House Insurance	
Pension		Property Taxes	
Interest		Automobile Payment	
Alimony		Automobile Insurance	
Land Contract Income		Life Insurance	
Rental Income		Medical Insurance	
Awards/Law Suits		Medication	
Food Stamps		Medical Expenses	
Veterans		Child Support/Alimony	
Inheritances		Child Care	
Other Household income		Gasoline	
Other (please specify)		Groceries	
Other (please specify)		Other (please specify)	

INSTALLMENT LOANS AND CREDIT CARDS

Creditor	Balance Owed	Monthly Payment

Total Income	Total Expenses

Please attach any further details regarding your Household Income and Expenses 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 do so could result in loss of financial assistance discount.

You must submit all **household 2018 Federal Income Tax Returns** and **current proof of income** with your application.
Your application is due back no later than ________________________.

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 as a charitable organization, Scheurer Healthcare Network may provide me with discounted or free care.

____ ________________________
Applicants Signature Date

____ ________________________
Spouse's Signature Date

Approvals are valid until the end of the current calendar year, upon which updated information will be required for any future service. Agreeable payment arrangements must be made for any remaining balance and can be re-evaluated at Scheurer Healthcare Networks discretion. ***I understand that no matter what discount I am approved for I will be required to pay $10 each visit prior to being treated at the doctors office or Redi-Care Clinic.***

Approved ☐ Denied ☐ ____ ______________________________
Approval Signature Date

Reason for Denial: