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	_____	_____	_____

Asset Information:	**Description (make/model/Year)**	**Fair Market / Blue Book Value**	**Balance of Debt (if any)**	**Equity (Book-Debt)**
Vehicle 2	_____	_____	_____	_____
Boat	_____	_____	_____	_____
Off Road Vehicles	_____	_____	_____	_____
Camper	_____	_____	_____	_____
Other (please specify)	_____	_____	_____	_____
Total	_____	_____	_____	_____

	Current Balance
Savings Accts	_____
Stocks/Other Investments	_____
Total	_____

Please attach a copy of the following:

1) Approval or denial letter from Medical Assistance
2) Prior year's federal income tax return
3) Copy of the most recent statement of all bank loans to support above asset information
4) 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