Mackinac Straits Health System

Charity Care Sliding Fee-Scale Application

Please complete the following application, attach the requested documents & return to:
MSHS Attn: Business Office, 1140 North State Street, St. Ignace, MI 49781 for consideration
Email: billing@mshosp.org Fax: (906) 643-0461

Name of Head of Household		Place of Employment		Yearly Salary
Street	City	State	Zip	Phone
Do you have a Health Insurance Plan? Yes ☐ No ☐		Social Security Number		

Please list spouse and dependents:

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income

Source	Household Assets
Gross wages, salaries, Tips, etc $	Checking account #1 balance $ _____ Name of Bank _____
Social Security, pension, annuity, and veterans benefits $	Checking Account #2 balance $ _____ Name of bank _____
Alimony, child support, miltary family allotments $	Savings account #1 balance $ _____ Name of Bank _____
Income from business, self employment and dependents $	Savings Account #2 balance $ _____ Name of Bank _____
Rent, interest, dividend, and other $	Other property: _____
Total income $	

Were you denied by the State for Medicaid assistance due to excess assets? Yes ☐ No ☐
If yes, please explain these assets: _____

Attach the following
Identification/Address: one of the following: Drivers License, birth certificate, Social Security Card
Income: Most recent tax return
Insurance: Insurance cards if applicable
Medicaid: Proof of application submitted and evidence of its acceptance or rejection

I certify that the information shown above is correct & understand verification is required for approval

Name (Print) _____

Signature _____ Date _____