SHERIDAN MEMORIAL HOSPITAL

Medical Assistance Application

Name: ______________________________ SSN: ___________________ Birthdate: _____________________

Spouse's Name: ______________________ SSN: __________________ Birthdate: _____________________

Tax Dependent Name: ____________________ SSN: __________________ Birthdate: __________________

Tax Dependent Name: ____________________ SSN: __________________ Birthdate: __________________

Tax Dependent Name: ____________________ SSN: __________________ Birthdate: __________________

Tax Dependent Name: ____________________ SSN: __________________ Birthdate: __________________

Address (Street): __________________________________ (Mailing): _________________________________

City/State/Zip: ____________________________________ Time at Residence: _________________________

Phone Number: ___________________ Text: Y / N Spouse Phone Number: __________________ Text: Y / N

Insurance: ☐ Yes ☐ No Insurance Type(s): ☐ Job-Based ☐ Marketplace ☐ Medicaid ☐ Medicare

☐ Cost-Share ☐ Other: ______________ Covered *Person(s):* _____________________________________

Ins Company: ____________________ *Member ID:* ____________________ *Group:* ____________________

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired Last day of work: ______________________

Employer: _____________________________ Employer's Phone Number: _____________________________

Job Title: ____________ ☐ Full Time ☐ Part Time ☐ Seasonal/Temp Start/End Dates: _______________

Spouse's Employment Status: ☐ Employed ☐ Unemployed ☐ Retired Last day of work: _____________

Spouse's Employer: _______________________ Employer's Phone Number: __________________________

Job Title: ____________ ☐ Full Time ☐ Part Time ☐ Seasonal/Temp Start/End Dates: _______________

Gross Income: __________ Source: _______________ Pay Rate: __________ Pay Frequency: _______________

Spouse's Gross Income: ____________ Source: ____________ Pay Rate: _________ Pay Frequency: _________

Workers Comp or Unemployment: Y / N Amount: ___________ Dates of Coverage: __________ to __________

Dividends/Trust Account: ________________________ Amount: ______________ Frequency: _____________

Alimony/Child Support: __________________________ Amount: ______________ Frequency: _____________

401K/Pension/IRA Account: ______________________ Amount: ______________ Frequency: _____________

Other Sources of Income: ________________________ Amount: ______________ Frequency: _____________

Other Sources of Income: ________________________ Amount: ______________ Frequency: _____________

☐ SNAP Amount: ______________ ☐ POWER Amount: ______________ ☐ LIEAP Amount: _____________

☐ Other Assistance ___________________ Amount: ___________ Frequency: ________________________

Please provide your monthly expenses. Documentation must be provided for each expense to be considered.

Rent/Mortgage:		Electric/Gas:	
Home Insurance Included:	☐ Yes ☐ No	Water/Sewer:	
Home/Renter's Insurance:		Internet:	
Propane:		Child Support:	
Garbage:		Car Insurance:	
Phone:		Outside Medical Bills:	
Car Payment(s):		Student Loan:	
Health Insurance:		Other:	

Please detail assets below. Assets are property or accounts owned by you and/or your household. Please note that additional information may be requested.

Type	Yes	No	Owner	Estimated Value	Description/Address
Primary Residence					
Property/Real Estate					
Vehicle					
Recreational Vehicle					
Off Road Vehicles					
Tractor/Equipment					
Livestock/Crops					
401 K/IRA/Pension					
CD/Stocks/Bonds					
Trust					
HSA					
Medical Fundraising					

Please explain your need for assistance. If additional room is needed, a letter can be attached.

____
____
____
____
____
____
____
____
____

Documentation Checklist:

Income:

- ☐ 3 Months Paystubs *or* Profit & Loss
- ☐ 3 Months Bank Statements for *ALL* Accounts
- ☐ 2 Years Tax Returns
- ☐ SSI/SSDI Award Letter
- ☐ Unemployment Letter
- ☐ Workers Comp Award Letter
- ☐ Child Support Statement
- ☐ Other Income Statements

Liabilities:

- ☐ Rent Receipt/Mortgage Statement
- ☐ Home Insurance Statement
- ☐ Electric/Gas Statement
- ☐ Propane Receipt
- ☐ Water/Sewer
- ☐ Garbage
- ☐ Phone
- ☐ Internet
- ☐ Child Support
- ☐ Car Payment
- ☐ Car Insurance
- ☐ Health Insurance
- ☐ Outside Medical Bills
- ☐ Student Loan Statement
- ☐ Other Costs Statements

Other Documentation:

- ☐ Medicaid Denial Letter or Marketplace Tax Credit Ineligibility Letter
- ☐ Denial Letter from SSI, SSDI, Unemployment, Worker's Comp, etc.
- ☐ Letter of No Income- Attestation of no income, why, and an explanation of how living expenses are paid. **If you are supported by another household member, their income information is required**.
- ☐ If you do not have proof of expenses or live with family or friends, an attestation letter with signature and date is required from the individual who pays the household expenses. Letter must detail the arrangement and expenses covered.
- ☐ Asset documentation. Examples include most recent statement for any Health Savings Account or Medical Fundraising accounts.
- ☐ Alternate Documentation: ____

All documentation and additional applications are due 30 days from the date of this application.

The information provided for this application is complete and correct to the best of my knowledge. I hereby grant Sheridan Memorial Hospital the authority to verify all information provided, my employment history, obtain a credit report and gather other information that may be necessary for the processing of this application. I understand that omission of income or assets will disqualify my household from medical assistance and approval will be reversed. I will apply for and maintain any third party coverage options I am eligible for including but not limited to Medicare, Medicaid, job-based or Marketplace health insurance, grant programs, etc. I understand failure to do so may result in the reversal of my approval. I understand that if I am granted assistance, my cost share amount is due in full within 60 days of the approval of my application. I understand if I fail to meet the financial responsibility, my approval is void. Only services deemed medically necessary per the program policy will qualify for medical assistance. I acknowledge that I have read and agree to the program policy. I agree to adhere to all policy requirements; failure to do so may result in a reversal of approval. If, for any reason, my approval is reversed, all balances will be sent to a collection agency and be my responsibility.

Applicant Signature: ____ **Date:** ______________________

Spouse Signature: ____ **Date:** ______________________

Potentially Eligible For: ___LINK ___WY Cancer Program ___Medicaid ___Medicaid Waiver ____Marketplace _____Medicare Extra Helps ___SNAP ___LIEAP ___POWER ___MAP ___Outside PAP ___Other: _______________

Advocate: __________________ **Date:** ___________ **[A] Applied [P] App Completed [E] Enrolled [D] Declined [X] Not Eligible**