SHERIDAN MEMORIAL HOSPITAL

Medical Assistance Application

Name: _____ SSN: _____ Birthdate: _____

Other Adult: _____ 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: _____

- Gross Income: _____ Source: _____Pay Rate: _____Pay Frequency: _____

Other Adult Employment Status: ☐ Employed ☐ Unemployed ☐ Retired Last day of work: _____

Other Adult Employer: _____ Employer's Phone Number: _____

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

- 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: _____

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
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.

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Documentation Checklist:

Required:
- ☐ 3 Months Paystubs *or* Profit & Loss
- ☐ 3 Months Bank Statements for *ALL* Accounts
- ☐ 2 Years Tax Returns
- ☐ SSI/SSDI Award Letter
- ☐ Proof of Residency (i.e. Utility Statement)
- ☐ Unemployment Letter
- ☐ Workers Comp Award Letter
- ☐ Child Support Statement
- ☐ Other Income Statement

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: _____

Optional Supporting Documentation:

- ☐ 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

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. 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 termination 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 agree to adhere to all policy requirements; failure to do so may result in termination of assistance. If, for any reason, my approval is terminated, all past-due balances will be sent to a collection agency and be my responsibility.

** I acknowledge that I have read and agree to the program policy. (initial here)_____

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**