Mackinac Straits Health System

Charity Care Sliding Fee-Scale Application

Please complete the following application, attach the requested documents & return to:
MSHS Attn: Patient Financial Services, 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
Gross wages, salaries, Tips, etc $
Social Security, pension, annuity, and veterans benefits $
Alimony, child support, miltary family allotments $
Income from business, self employment and dependents $
Rent, interest, dividend, and other $
Total income $

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 _____