Mackinac Straits Health System
AN AFFILIATE OF MyMICHIGAN HEALTH

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

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, military 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
Income: Most recent tax return
Insurance cards, if applicable (Not applicable for primary care services in the ambulatory or rural health clinics)
Proof of submitted Medicaid application with evidence of acceptance or rejection (Not applicable for primary care services in the ambulatory or rural health clinics)

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

Name (Print) _____

Signature _____ Date _____