SACRED HEART
MERCY HEALTH CARE CENTER
2025 W CHESSMAN RD., ALMA, MICHIGAN 48801

phone (989) 463-3451 *fax (989) 463-1534*

FINANCIAL REVIEW WORKSHEET – FREE CARE

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE) _____ DATE _____ ☐ NEW ☐ RETURN

BIRTH DATE _____ AGE _____ ☐ MALE ☐ FEMALE

SECTION 1

ON FILE	N/A	DOCUMENT	ESTIMATED AMOUNT	MONTHLY AMOUNT
		Federal 1040 Income Tax Return (Last Filed)		
		Social Security Income		
		Check stubs or employer printout (last 2 months)		
		Rental income		
		Alimony		
		Child Support		
		Pension Income Statement		
		Unemployment Compensation		
		Worker's compensation/disalbility		
		Union Benefits		
		Retirement Funds		
		Other		
OFFICE USE ONLY		Monthly Total		
		Yearly Total		

I understand that failure to provide proof of income and application to Medicaid (if applicable) within 30 days will result in denial of any further services offered free of charge by Sacred Heart Mercy Health Care Center.

PATIENT SIGNATURE _____ WITNESS _____ DATE _____

SECTION 2

COMMENTS		
DATE RECEIVED	☐ APPROVED ☐ DENIED	DETERMINATION MAILED
INTAKE COORDINATOR SIGNATURE		DATE