HEALTHCARE EXPENSES RELIEF PROGRAM

Sliding Fee Application

DATE OF REQUEST:

Last Name_____ First_____ M.I._____
Address_____ City, State, Zip _____
Date of Birth_____
Home Phone#_____ Cell Phone#_____
Name of Employer_____ Work Phone# _____

Household Size (include yourself) _____

List Each Household Member's Name/Age

_____

_____

List Each Household Member's Name/Age

_____

_____

List below description of income (monthly) amount for household

Income _____ $_____ Income_____ $_____
Checking _____ $_____ Other _____ $_____

I understand that the information, which I submit, is subject to verification by Helen Newberry Joy Hospital & Healthcare Center, and subject to review by federal/state enforcement agencies and others as required. I certify that the above information is a full, accurate description of the facts. Furthermore, I authorize Helen Newberry Joy Hospital to release/transfer information to the Community Health Access Coalition at 505 Washington Blvd. Newberry, MI 49868 to facilitate the intake process.

_____
Signature of Person Making Request

Revised 4/04/2022