Address: 4008 W Wackerly St
PO Box 2225
Midland MI 48641-2225
Phone: (989) 839-0534
Fax: (989) 839-0537

Michigan Health Endowment Fund Request Form

Requestor Name: ______________________________Date:________________________________
Address: ____
Phone Number: ____________________________ Email: _________________________________
County of residence: _____________________________

Child(ren) Name	DOB	MiSACWIS Case ID#	Person ID#	DHHS County

Type of Service (Medical, Dental, Vision, annual or biannual, For License, For Adoption, For Home study, etc.)	**Date of Service** (mm/dd/yyyy)	**Location of Service** (Provider name and address)	**Brief Summary** (explanation of services needed)	**Requested Amount**	**Amount family can assist with**	**Amount covered**

Please check all that apply: (mark N/A if not billable to program):

_____ **Primary insurance Billed** _____ **MI Child Billed**

_____ **Applied for CSHCS funds** _____ **Qualify for subsidy**

Does your family fall above or below the Federal level of poverty? Yes or No

2016 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA (HHS Poverty Guidelines for 2016) If your family has additional members please call for amount based on the number in your household. Household Annual income_______________________

Persons in family/household	Poverty guideline	Persons in family/household	Poverty guideline
1 person	$11,880	2 people	$16,020
3 people	$20,160	4 people	$24,300

____
DHHS Worker (Agency Worker) (County) Date

____
MHEF Staff Date

____
MHEF Supervisor Date

. . . .

Revised 12-9-16