| Patient:_____ | Loc: 1 2 3 4 5 6 | Staff Initial_____ |
|---|---|---|
| _____ | Ped WHC | Pharmacy:___ Medical: ___ |

Isabella Citizens for Health, Inc.
2790 Health Parkway, Mt. Pleasant MI, 48858

# Sliding Fee Discount Program Instructions

The Sliding Fee Scale Program will be provided to eligible patients based on their ability to pay. Ability to pay is determined by the household size and the annual household gross income. The Sliding Fee Rate Schedule is based on the most recently published Federal Poverty Guidelines, issued annually by the U.S. Department of Health and Human Services.

For purposes of the Sliding Fee Discount Program, the term "household" is defined as any persons, related or unrelated, living in the same dwelling who share household expenses. This definition includes unrelated roommates (non-college) who share the cost of rent, utilities, food, or household supplies. Individuals who reside in a boarding house, residence hall, or other dwelling where household expenses are completely independent are not considered a household. If applicant is a single parent household and claiming dependent children in household, applicant must give proof of child support or reason why they don't receive child support for your children. Please indicate under the special consideration section below.

Definition of gross household Income is the total annual cash receipts before taxes from all sources including salaries, public assistance, unemployment, retirement payments, Social Security, child support, etc.: but excluding gifts, receipts from sale of property, or non-cash benefits such as Medicaid, food stamps, public housing, etc. (Dept. of Health and Human Services).
Income from children over the age of 19 and still living at home must be included in total family income.

You should provide as many of the documents listed below as possible for each person in the household that contributes to the household expenses.

- Most recent Federal 1040 Income Tax Return (W-2's not accepted)
- Most recent two pay stubs (or any other form of paycheck verification)
- Bank Statements- one month's worth
- Social Security Award Letter for the Current Year
- Disability Income
- Unemployment Benefit Determination Statement
- Child Support Income
- Alimony Income
- Retirement Payment(s) Documentation
- Monthly Pension Statement or Most Recent 1099
- Worker's Compensation Checks
- Student Loan Income Award Letter/Stipend/Award Letter (for students)
- Rental and Land Contract Income
- Cash Payment for Services Rendered (when a 1099 is not issued)

If you do not have any income, or are homeless, include a letter from the person who supports with the application. If you do not have a support person, contact the Billing Office, 989-779-5642, to complete the application.

Regarding Approval:

If approved, you will be asked to re-verify your household size and gross income on an annual basis to continue to receive the sliding fee scale. You are also obligated to contact Isabella Citizens for Health's Billing Office if your income or household status changes.

If you did not bring appropriate documentation, you may "self-declare" your income for one initial visit. Self-declaration is only acceptable for an initial visit. You will be charged for the initial visit according to your reported income. If you self-declare, you will need to complete the sliding fee discount application before your next visit or within 30 days, whichever is sooner. Final eligibility will be applied to future visits unless your circumstances change.

Anyone who is unwilling to provide proper documentation may not be eligible to participate in the Sliding Fee Discount Program and will be required to pay 100% of charges.

All uninsured applicants will be assisted in applying for publicly available insurances, such as Medicaid or the Health Michigan Plan. Failure or refusal to complete the application process will result in a redetermination of eligibility in the Sliding Fee Discount Program.

Regarding Payment, if approved:

You will have to pay the discounted payment at time of service. It is expected that you make continuous efforts to pay any balances. You will be billed in a manner consistent with payment and collection policies similar to other businesses. You will be billed monthly, and accounts are expected to be kept current. After 90 days of account inactivity, you will be contact regarding your outstanding balance.

| Patient:_____ | Loc: 1 2 3 4 5 6 | Staff Initial_____ |
|---|---|---|
| _____ | Ped WHC | Pharmacy:___ Medical: ___ |

# Isabella Citizens for Health
# Sliding Fee Discount Program Application

Application Date: _____

Head of Household's Name: _____

Address: _____

City/State/Zip:_____

Telephone: _____

Date of Birth: _____

Do you have any type of insurance to cover all or a portion of your medical expenses?

___ No ___Yes

If yes, Type(s) of Insurance: _____

| *Household Size* Please list information below for ALL other persons living in your household (If there are more than six members of your household, please list on a separate page). | | | |
|---|---|---|---|
| Full Name | Relationship to patient | Date of Birth | Employer |
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| Patient:_____ | Loc: 1 2 3 4 5 6 | Staff Initial_____ |
|---|---|---|
| _____ | Ped WHC | Pharmacy:___ Medical: ___ |

| Household Income | | | | | |
|---|---|---|---|---|---|
| Source of Income | You | Spouse Or Partner | Children | Other | Frequency (circle one) |
| Salaries/Wages | | | | | Weekly Bi-Weekly Monthly Yearly |
| Social Security | | | | | Weekly Bi-Weekly Monthly Yearly |
| Public Assistance | | | | | Weekly Bi-Weekly Monthly Yearly |
| Unemployment | | | | | Weekly Bi-Weekly Monthly Yearly |
| Retirement/Pension | | | | | Weekly Bi-Weekly Monthly Yearly |
| Child Support | | | | | Weekly Bi-Weekly Monthly Yearly |
| Alimony Support | | | | | Weekly Bi-Weekly Monthly Yearly |
| Disability Income | | | | | Weekly Bi-Weekly Monthly Yearly |
| Worker's Compensation | | | | | Weekly Bi-Weekly Monthly Yearly |
| Other_____ | | | | | Weekly Bi-Weekly Monthly Yearly |

I declare the above information is accurate and I grant Isabella Citizens for Health, Inc. permission to verify any information provided in this application. I understand that this information is kept in the strictest confidence. I also understand that should my income change, I am required to notify the appropriate a health center staff member before or at my next Center visit. Appropriate staff may include a receptionist, billing staff person, pharmacy staff person or School-based staff person.

_____ _____

Applicant's Signature Date

*Do not write below this line. For office use only.*

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Approved/Denied Effective Date: _____ Income Level: _____

Explanation for denial: _____

CEO Approval/Denial:_____ Date:_____

Date Patient Informed: _____ Informed By:_____

Informed How: _____

*Last modified: 03-22-2023*