Sliding Fee Scale Eligibility

Even if you have insurance, you may qualify for our discounted fees for services.

PATIENT NAME:_______________________________________

Form Instructions:

Step 1: Please list **ALL** members of the household, including yourself.

Step 2: Please list **ALL** sources of annual income for each member of the household.

Step 3: Please provide proof of income within **30 days**. Examples of proof of Income: **1040, W-2, or 1 month of paystubs.**

Step 4: Please sign form accordingly.

STEP 1: Household Members Please list ALL members of the household, including YOURSELF.

	Name	*Relationship to the patient*	*Date of Birth*	*Workplace*	*Full/Part Time*
1.		Self			
2.					
3.					
4.					
5.					
6.					

STEP 2: Annual Household Income- Please list ALL sources of income for each member of the household

Type of Income:	*Member 1 (You):*	*Member 2:*	*Member 3:*	*Member 4:*
Employment (including tips)	$	$	$	$
Unemployment Compensation				
MI Bridges Cash Assistance				
Spousal Support, Child support				
Pension				
Social Security				
Other				
TOTAL INCOME	**$**	**$**	**$**	**$**

STEP 3: Proof of Income- Please provide proof of income within 30 days, or you may be billed for the full amount for the services provided. Bring your proof of income to your next visit.

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am eligible for the sliding fee scale discount, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. It is the policy of this organization to provide equal opportunities without regard to race, color, and religion.

STEP 4: Signature

Patient/Guardian:
Date:
Print Guardian Name:
Relationship:

The most you will pay per visit:	Plan A **$20 Medical $30 Dental**	Plan B **$30 Medical $40 Dental**	Plan C **$40 Medical $55 Dental**	Plan D **$55 Medical $75 Dental**	Plan E No Discount – you pay full charges
Family Size	Annual Household Income	Annual Household Income	Annual Household Income	Annual Household Income	Annual Household Income
1	$0 - $14,580	$14,581- $21,870	$21,871- $26,973	$26,974- $29,160	greater than $29,160
2	$0 - $19,720	$19,721- $29,580	$29,581- $36,482	$36,483- $39,440	greater than $39,440
3	$0 - $24,860	$24,861- $37,290	$37,291- $45,991	$45,992- $49,720	greater than $49,720
4	$0 - $30,000	$30,001- $45,000	$45,001- $55,500	$55,501- $60,000	greater than $60,000
5	$0 - $35,140	$35,141- $52,710	$52,711- $65,009	$65,010- $70,280	greater than $70,280
6	$0 - $40,280	$40,281- $60,420	$60,421- $74,518	$74,519- $80,560	greater than $80,560
7	$0 - $45,420	$45,421- $68,130	$68,131- $84,027	$84,028- $90,840	greater than $90,840
8*	$0 - $50,560	$50,561- $75,840	$75,841- $93,536	$93,537- $101,120	greater than $101,260

*For family household units of more than 8 members, add $5, 140 per year per additional person. Effective 3/1/23 – 2/28/24

To arrange a payment plan, call NMHSI Financial Department @ (231) 947-0351. ***Revised: 3/17/2023***