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|  Northwest Michigan Health Services, Inc.Need **affordable** Medical, Dental, or Behavioral Health Care?We’ve got you covered!**G:\Logo\Butterfly-NMHSI.jpg** **Sliding Fee Scale Eligibility**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 ENo Discount – you pay full charges |
| Family Size | Monthly Household Income | Monthly Household Income | Monthly Household Income | Monthly Household Income | Monthly Household Income |
| 1 | $0 - $1,133 | $1,134 - $1,699 | $1,700 - $2,095 | $2,096 - $2,265 | Greater than $2,265 |
| 2 | $0 - $1,526 | $1,527 - $2,289 | $2,290 - $2,823 | $2,824 - $3,052 | Greater than $3,052 |
| 3 | $0 - $1,919 | $1,920 - $2,879 | $2,880 - $3,550 | $3,551 - $3,838 | Greater than $3,838 |
| 4 | $0 - $2,313 | $2,314 - $3,469 | $3,470 - $4,278 | $4,279 - $4,625 | Greater than $4,625 |
| 5 | $0 - $2,706 | $2,707 - $4,059 | $4,060 - $5,006 | $5,007 - $5,412 | Greater than $5,412 |
| 6 | $0 - $3,099 | $3,100 - $4,649 | $4,650 - $5,733 | $5,734 - $6,198 | Greater than $6,198 |
| 7 | $0 - $3,493 | $3,494 - $5,239 | $5,240 - $6,461 | $6,462 - $6,985 | Greater than $6,985 |
| 8\* | $0 - $3,886 | $3,887 - $5,829 | $5,830 - $7,189 | $7,190 - $7,772 | Greater than $7,772 |
| \*For family household units of more than 8 members, add $393.33 per month per additional person. |

Even if you have insurance, you may qualify for our discounted fees for services.*Plus, we can connect you to other resources that might be helpful:** food
* housing
* transportation
* legal services
* clothing
* child care
* more!
 |  |

 **Household Members** Please list **ALL** members of the household.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Name*** |  ***Relationship to the patient*** | ***Date of Birth*** | ***Work Place*** | ***FT/PT*** |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |

**Household Income** Please list ALL sources of income for each member of the household.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Type of Income:*** | ***Member 1:*** | ***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** |  |  |  |  |

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. **I am aware that if I do not provide proof of income within 30 days, that I may be billed for the full amount for the services provided.**

|  |  |
| --- | --- |
| Signature: |  Date: |