NORTHWEST MICHIGAN HEALTH SERVICES INC

SLIDING FEE SCALE ELIGIBILITY

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

	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	$15,650	$15,651	$23,475	$23,476	$28,953	$28,954	$31,300	greater than $31,300
2	$0	$21,150	$21,151	$31,725	$31,726	$39,128	$39,129	$42,300	greater than $42,300
3	$0	$26,650	$26,651	$39,975	$39,976	$49,303	$49,304	$53,300	greater than $53,300
4	$0	$32,150	$32,151	$48,225	$48,226	$59,478	$59,479	$64,300	greater than $64,300
5	$0	$37,650	$37,651	$56,475	$56,476	$69,653	$69,654	$75,300	greater than $75,300
6	$0	$43,150	$43,151	$64,725	$64,726	$79,828	$79,829	$86,300	greater than $86,300
7	$0	$48,650	$48,651	$72,975	$72,976	$90,003	$90,004	$97,300	greater than $97,300
8	$0	$54,150	$54,151	$81,225	$81,226	$100,178	$100,179	$108,300	greater than $108,300

*For family household units of more than 8 members, add $5,500 per annual per additional person. Effective 3/15/25

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: _____

Revised: 2/25