Sliding Fee%_____
Review date_____

APPLICATION FOR SLIDING FEE DISCOUNT

Michigan-Wisconsin Family Practice Associates, P.C. offers a sliding payment scale on which fees are determined by household size and income. If you are eligible for Medicaid or Medicare you need to apply directly to those programs and let us know when you receive your Medicaid and/or Medicare card.

NAME_____ DATE OF BIRTH_____ PHONE _____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HAVE YOU APPLIED FOR MEDICAID WITHIN THE LAST YEAR? YES NO

If eligible for Spendown, provide amount $_____

LIST BELOW ALL HOUSEHOLD MEMBERS (INCLUDING YOURSELF)

NOTE: Dependents over age 18 will be asked to provide proof of income also.

NAME	RELATIONSHIP	AGE	NAME OF ANY MEDICAL INSURANCE
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

	INCOME PER MONTH
ENTIRE GROSS HOUSEHOLD WAGES	_____
CHILD SUPPORT/ALIMONY	_____
PUBLIC ASSISTANCE	_____
UNEMPLOYMENT COMPENSATION	_____
WORKERS COMPENSATION	_____
SOCIAL SECURITY/PENSION	_____
OTHER	_____

PROOF OF ALL INCOME MUST BE ATTACHED TO BE CONSIDERED.
Copy of current tax return
Current wage or other income

Income. List any money your household receives; examples of income are: Salaries before taxes, unemployment benefits, workers compensation benefits, public assistance, SSI, strike benefits, veterans benefits, alimony, child support, military family allotments, pension, insurance of annuity payments, dividends payments, interest, rent royalties, and business income or non-cash benefits such as Medicaid, food stamps, public housing, etc.

-CERTIFICATION-

I hereby certify that all of the information on this form is true and accurate to the best of my knowledge. I will provide available verification or documentation, as requested by MI-WI Family Practice Assoc., P.C. I also understand that this information will be kept confidential and used only by MI-WI Family Practice Assoc., P.C. for fee adjustment purposes. If there is a change in any of this information, I will be responsible for informing the clinic and if I fail to disclose changes in income or family size, I understand that I may be disqualified from further discounts.

I UNDERTAND THAT SLIDING FEE PATIENTS ARE REQUIRED TO PAY THEIR PART OF THE BILL AT THE TIME OF SERVICE

_____ _____

Applicant or Authorized Representative Date Signed

SLIDING FEE WILL NOT BE APPROVED UNTIL ALL INFORMATION IS RECEIVED.