**Michigan-Wisconsin Family Practice Associates, P.C.**

**APPLICATION FOR SLIDING FEE DISCOUNT**

Our office 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 code\_\_\_\_\_\_\_\_\_

Medicare: Y / N Insurance: Y / N HAVE YOU APPLIED FOR MEDICAID WITHIN THE LAST YEAR? Y / N

If eligible for Spendown, provide amount $\_\_\_\_\_\_\_\_\_\_\_

LIST BELOW ALL **HOUSEHOLD MEMBERS** (Self, Spouse, Children, Other)

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

NAME RELATIONSHIP AGE NAME OF ANY MEDICAL INSURANCE MONTHLY GROSS

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INCOME PER MONTH **PROOF OF ALL INCOME**

ENTIRE GROSS HOUSEHOLD WAGES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MUST BE ATTACHED TO**

CHILD SUPPORT/ALIMONY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **BE CONSIDERED.**

PUBLIC ASSISTANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copy of current tax return

UNEMPLOYMENT COMPENSATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current wage or other income

WORKERS COMPENSATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2 pay stubs from all members)

SOCIAL SECURITY/PENSION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If applicable, any other sources of income

OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, 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. If applicable, this discount will be applied only to the amount due after my insurance pays the amount for which I am covered. Some procedures or services may not be covered by this discount, or there may be acquisition fees.

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**Applicant** or Authorized Representative Date Signed

Any applicant claiming “zero income” must sign a Zero Income Affidavit.

This is a legally binding document in which false statements constitute fraud.

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