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
__________________________	__________	___	_________________________	____________
__________________________	__________	___	_________________________	____________
__________________________	__________	___	_________________________	____________
__________________________	__________	___	_________________________	____________
__________________________	__________	___	_________________________	____________
__________________________	__________	___	_________________________	____________

	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
(2 pay stubs from all members)
If applicable, any other sources of 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, 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.

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

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.