Hackley Community Care Center
2700 Baker Street
Muskegon Heights, MI. 49444
231-737-1335

Dear ________________________________:

On __________________________________, you requested the Sliding Fee Scale to reduce your payment to the Hackley Community Care Center.

( ) Your income exceeds the standards for this program and we are sorry to inform you that your request has been denied. Should your circumstances change, please notify us and a new application will be taken.

( ) Your application was approved.

- Hackley Community Care Center Medical/OB Care your co-pay will be $__________
- Hackley Community Care Center Dental co-pay will be a minimum of $15.00 and you will be at a level_________. Please contact Dental regarding your charges.
- Community Care Pharmacy Service: please contact them regarding your discount

Sliding Fee Scale Begin Date: ____________________________

Sliding Fee Scale Review Date: ____________________________

To help identify our sliding fee scale patients, you will be given a sliding fee scale card. Your signature is required to obtain your card for yourself or your minor children.

You must present your current sliding fee scale card each time you receive services at the Hackley Community Care Center, Community Care Pharmacy, and Mercy and Hackley Hospital Campus. Services covered under the sliding fee scale will be explained to you when you pick up your card.

Thank you,

Hackley Community Care Center Staff

FAMILY MEMBERS COVERED	DATE OF BIRTH

Hackley Community Care Center
Sliding Fee Payment Scale
Income Verification Form

The Hackley Community Care Center offers to its patients, a SLIDING FEE PAYMENT SCALE for patient fees determined by family size and income. An application for Medicaid can also be taken at this time.

The application for the patient Sliding Fee Payment Scale will be reviewed annually to determine eligibility

Are you presently receiving Medicaid or Medicare? ____ Yes ____ No

Applicant's Name ______________________________ Ph. # ____________

Address _________________________________City____________________ Zip Code _______

COUNTY: ______________________________

Applicant's Date of Birth: ________________

List All Family Members dependent on income:

Name: ____ Relation: _____________Age__________

Name: ____ Relation: _____________Age__________

Name: ____ Relation: _____________Age__________

Name: ____ Relation: _____________Age__________

Name: ____ Relation: _____________Age__________

Name: ____ Relation: _____________Age__________

Name: ____ Relation: _____________Age__________

Name: ____ Relation: _____________Age__________

Please tell us how you heard about our Sliding Fee Scale program:

_____**renew** ______ **friend** ________________________ **other**

_____**staff** ______ **MCHP (Muskegon County Health Project)**

Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved and will be provided as may be requested.

<u>List total Gross income in Household</u>:	**Weekly**	**or Monthly**	**= Annual**
Wages/Salary/Tips…………………….........	______________	______________	______________
Business/ Farm Income…………………..	______________	______________	______________
Disability Payment……………………….	______________	______________	______________
Social Security……………………………	______________	______________	______________
Unemployment Compensation…………...	______________	______________	______________
Worker's Compensation………………….	______________	______________	______________
Union Benefits……………………………	______________	______________	______________
Alimony………………………………….	______________	______________	______________
Child Support…………………………....	______________	______________	______________
Pension/ Retirement……………………..	______________	______________	______________
Net Income from Rental Property………	______________	______________	______________
Odd Jobs…………………………………	______________	______________	______________
Total……………………………………..	______________	______________	______________

<u>List expenses for the following:</u>

Medical costs…………………………….	______________	______________	______________
Day Care Costs…………………………..	______________	______________	______________
Child Support Paid………………………	______________	______________	______________
Total……………………………………….	______________	______________	______________

I understand that any change in income must be reported within thirty (30) days, and I attest that this statement of family annual income is true and accurate to the best of my knowledge, and that all statements made by me in this application are true.

I understand that the information is subject to verification by Hackley Community Care Center and is subject to review of federal and/or state enforcement agencies and others as required.

____ ______________________

(Signature) **(Date)**

HACKLEY COMMUNITY CARE CENTER
MEDICAL & DENTAL SERVICES

I_________________________________ currently do not have any income. I will notify Hackley Community Care Center if my income changes.

If your income is “0 “, please describe how your basic needs are being met such as shelter, personal care items, food, transportation, etc:

____

____

____

Please list the current amount you are receiving from DHS if any:

Food Assistance $____________

Cash Assistance $____________

Sliding Fee Scale Calculation Worksheet

BEGIN DATE: _________________

END DATE: _________________

FAMILY NAME: ____________________________ RETRO TO: _________________

NOTES:

____

____

VERIFICATION:

_____ Identification

_____ Date of Birth

_____ Social Security Number

_____ Adolescent Patient

_____ Self-declaration used for eligibility

INCOME CALCULATIONS:

Level: _______________

Co-pay Client Pays $_______________

____

Signature of Preparer