HACKLEY COMMUNITY CARE
For Your Whole Life

2700 Baker Street Muskegon
Heights, MI. 49444
231-737-1335

Dear _____:

On _____, you requested an application for our Sliding Fee Scale Discount Program.

( ) 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.

( ) We did not receive enough information to process your application.

( ) Your application was approved.

- Hackley Community Care Center reduced fee for Medical/OB/Mental Health services will be $_____
- Hackley Community Care Center reduced fee for dental preventative services are $_____ and reduced fee for dental additional services are $_____. Please contact the Dental Department regarding any additional charges for lab services. Note: Cosmetic procedures are not covered under Sliding Fee Scale Program.
- Community Care Pharmacy Service: please contact them regarding your discount.

Sliding Fee Scale Begin Date: _____

Sliding Fee Scale Review Date: _____

Your application for the Sliding Fee Discount Program will be reassessed every 12 months to determine eligibility.

To help identify our sliding fee scale patients, you will be given a sliding fee scale card.

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

FAMILY MEMBERS COVERED	DATE OF BIRTH

Hackley Community Care Center
Sliding Fee Scale Discount Program
Income Verification Form

Hackley Community Care Center is pleased to offer a reduced fee schedule based solely on family size and income. An application for Medicaid can also be taken at this time.

The application for the Sliding Fee Discount Program will be reviewed annually to determine eligibility unless changes to patient income or size occur prior to that time.

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.

List total Gross income in Household:	**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 self-attested……..	_____	_____	_____
Total……..	_____	_____	_____
List expenses for the following:			
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 for odd jobs used for eligibility

INCOME CALCULATIONS:

Level: _____

Reduced Fee Client Pays $_____

_____

Signature of Preparer