SLIDING FEE APPLICATION

Once your application is submitted for review & upon approval, you may be eligible for a discount ranging from fifty-five percent (55%) to ninety-five percent (95%) based on your household size & monthly income.

If approved, coverage will apply to Clinics visits, Emergency Department visits & outpatient lab work & radiology services. Applicants approved for this program will be eligible for one (1) year from the date of decision.

Applicants who are approved are responsible to pay their percentage at the time of service for non-emergency and other non-medically necessary care or make arrangements in advance with the Financial Counselor.

Please complete the following application & return with the following documentation:

- All monies received within the last sixty (60) days (pay stubs, government letter of assistance or copy of check or child support payments) for all members of household.
- Copy of last income tax return or letter explaining why you do not file.
- W-2s, 1099s for previous tax year.
- Two (2) most recent bank statements.
- Photo ID for all adults in the household. Social Security card for all members of the household (or birth certificate).
- Rent receipt or current utility bill showing current address.
- If rent and/ or utilities are provided by employer, please provide verification & value signed & dated by employer.
- If during the review of your application it appears you or a member of your household may be eligible for a state or federal program, you may be required to submit an application before approval of the Sliding Fee Scale Application. If an applicant is found to qualify for an assistance program, the Sliding Fee Scale Application will be amended to reflect that.

Please allow up to fourteen (14) days for processing of application.

South Lyon Medical Center is an equal opportunity provider. South Lyon Medical Center reserves the right to resent or deny approval of any discount if the applicant knowingly & willfully submits information that is identified or found to be fictitious.

Any changes in come or family size must be reported within ten (10) days.

If you have any questions regarding the program, please feel free to contact the Financial Counselor.

463-2301 ext. 6437

STATEMENT OF FINANCIAL CONDITION (Attachment A)

PATIENT NAME _____ SPOUSE _____

ADDRESS _____ PHONE _____

ACCOUNT # _____ SSN: _____ _____

(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents eighteen (18) years of age or under, full time student, or disabled.

Proof of student or disability may be required.

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT & OCCUPATION

Employer (or business name): _____Position:_____

Contact Person & Telephone: _____

Spouse Employer: _____ Position: _____

Contact Person & Telephone: _____

CURRENT MONTHLY INCOME

Start: Gross Pay (before deductions) _____

Add: Income from Operating Business (if Self-Employed) _____

Add: Other Income:

Interest & Dividends _____

From Real Estate or Personal Property Social Security_____

Other (specify): _____

Alimony or Support Payments Received _____

Subtract: Alimony, Support Payments Paid (_____)

Equals: Total Current Monthly Income (add Patient+ Spouse Income from above)_____

FAMILY SIZE

Total Family Members (add patient, spouse & dependents from above) _____

This institution is an equal opportunity provider

By signing this form, I agree to allow South Lyon Medical Center & its representatives to check employment & credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

_____ _____

(Signature of Patient or Guarantor) (Date)

_____ _____

(Signature of Spouse) (Date)