SLIDING FEE APPLICATION

Once your application is submitted for review and 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 and monthly income.

If approved, coverage will apply to Clinics visits, Emergency Department visits and outpatient lab work and 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 and 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 and value signed and 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 and 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 and its representatives to check employment and 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)

CHARITY CARE CALCULATION WORKSHEET

Patient Name: ___________________________________ Patient Account #: _____________________

Special Considerations/Circumstances:

____

____

	Yes	No
Does Patient have Insurance?	☐	☐
Is Patient Eligible for Medicare?	☐	☐
Is Patient Eligible for Medicaid?	☐	☐
Is Patient Eligible for Other Government Programs (I.e. Crime Victims, etc.)?	☐	☐
Is Patient Self-Pay?	☐	☐

Charity/Financial Assistance Calculation:

Total Combined Current Monthly Income **$** ________________

Family Size (From Statement of Financial Condition) ________________

Qualification for Charity Care/Financial Assistance (circle one): Full Partial

(Identify using eligibility guide) Catastrophic No Eligibility

Partial Charity Write-off Calculation (complete this section only if patient qualifies for partial charity care):

A. Total Charges **$** ________________
B. Sliding fee % (Attachment B) ________________
C. Patient Liability (Line A times Line B) $ ________________
D. Discount Amount (Line A minus line C) **$** ________________

Catastrophic Charity Write-off Calculation (complete section only if patient qualifies for catastrophic charity w/o):

A. Patient Liability $ ________________
B. Annual Income $ ________________
C. Patient Liability as Percent of Annual Income ________________%
D. Is Line A divided by Line B greater than .30 (30%)? Yes No
E. If no, patient is not eligible for this type of write-off _______ $0________

F. If yes, multiply Line B by 30% to identify the patient liability amount $ ________________
G. If yes, Subtract line F from Line A to identify the write-off amount $ ________________

Total Amount of Recommended Charity Write-off(s): $ ________________

Worksheet Completed by: ______________________________________ Phone: _________________

Approved by: ____

AUTHORIZED FOR CHARITY WRITE-OFF

APPROVAL MATRIX: to be developed by each entity in accordance with departmental make-up, levels of management and size. For example:

Chief Executive Officer and/or Chief Financial Officer	Above $10,000
Chief Executive Officer/ Chief Financial Officer	Up to $10,000
Chief Executive Officer/ Chief Financial Officer	Up to $1,000

____

Approval Signature(s)

____

____

Date: ________________

NOTIFICATION FORM ELIGIBILITY DETERMINATION FOR CHARITY CARE

South Lyon Medical Center has conducted an eligibility determination for charity care for:

____________________________ ____________________________ _____________________________

PATIENT'S NAME ACCOUNT NUMBER DATE (S) OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on _______________.
This determination was completed on: _______________________________.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

___________ Your request for charity care has been approved for services rendered on
After applying the charity care reduction, the amount owed is $ __________________.

____________ Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

____

____

____

____

____

___________ Your request for charity care has been denied because:

REASON:

____

____

____

____

If you have any questions on this determination, please contact:

Financial Counselor 463-2301 ext. 6437