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 one hundred percent (100%) based on your household size and monthly income.

If approved, coverage will apply to Primary Care Clinic visits, Emergency Department Visits, Inpatient Visits, and outpatient services including Physical Therapy, Radiology, and Laboratory. Long Term Care Custodial Services are excluded from this Discount. Applicant(s) approved for this program will be eligible for one (1) year from the date of decision.

Applicant(s) who are approved are responsible for paying 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, Social Security Annual Benefit Letter, Pension, Retirement or copy of check or child support payments) for all members of household.

OR

- Copy of last income tax return or letter explaining why you do not file.

OR

- W-2s, 1099s for previous tax year.

AND

- Photo ID for all adults in the household: Valid Driver's License or Valid Identification Card, Valid Passport, or employment identification or other not specific.

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(s) knowingly and willfully submits information that is identified or found to be fictitious.

Any changes income 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 # _________________________

(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents eighteen (18) years of age or under, full time student, or disabled who reside in the household. Proof of student or disability may be required.

FAMILY SIZE

Name	Age	Date of Birth	Insurance (OPTIONAL)

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

EMPLOYMENT & OCCUPATION (Optional)

Employer (or business name): ____________________________Position: ______________________

Spouse Employer: ______________________________ Position: _____________________________

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
TOTAL INCOME			

Special Considerations/Circumstances:

____

____

This institution is an equal opportunity provider

Certification: I hear by certify that, to the best of my knowledge, that the provided information is true and accurate.

______________________________ ______________________

(Signature of Patient or Guarantor) (Date)

______________________________ ______________________

(Signature of Spouse) (Date)

CHARITY CARE CALCULATION WORKSHEET – FACILITY USE ONLY

Patient Name: ________________________________ Patient Account #: ____________________

Charity/Financial Assistance Calculation:

Total Combined Current Monthly Income $ ____________________

Family Size (From Statement of Financial Condition) ____________________

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): **$** ______________

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

Approved Sliding Fee % ___________________%

Received Date: __________________ Approval/Denial Date: _________________

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

(Identify using eligibility guide) Catastrophic Denied

Completed by: ______________________________________ Date: _________________

Approved by: _______________________________________ 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