Board Approved
Date: June 1, 2016

MUSKEGON FAMILY CARE
2201 S. GETTY STREET
MUSKEGON, MI. 49444

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Date of Birth: _____

SSN: _____ Chart Number: _____

Sliding Fee Scale Eligibility

It is necessary for us to ask personal questions in order to confirm your level of discount on our sliding fee scale. The information you provide will be kept in the strictest of confidence. You will be asked to verify your income annually. We require a copy of last year's tax return/ W2's. We may also request additional documentation such as pay stubs, social security checks, or proof of other forms of income.

Do you have any type of insurance to cover all or a portion of your medical and dental expenses? _____Yes (list below) _____No

Medical: _____ Dental: _____

Household Information

Date: _____ Number of people living in your household: _____

Marital Status: Married_____ Widow(er) _____ Single_____ Divorced_____ Separated_____ Partnered_____

Do you own or rent your home? Own_____ Rent_____ Live with someone_____ Other_____

Employment Status: Employed_____ Full time_____ Part Time_____ Unemployed_____ Retired_____ Disabled_____

Place of employment: _____You

_____Spouse

_____Children

_____Others in the house

Please provide the Name and Date of Birth for each individual living in your household: **(must be related by birth, marriage, or adoption and residing together in the same household).**

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

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Muskegon Family Care receives 8% of its funding through the Department of Health and Human Services/Health Resources and Services Administration.

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Please provide the amount of income that you or others in your household receive from the following sources:

Source (Monthly Income)	Your	Your Spouse	Your Children	Others	Total Amount
Wages					
Unemployment					
Social Security Benefits					
Alimony/Child support					
Retirement Benefits					
Govt. Assistance (include VA and disability)					
Interest, dividends					
Student Loans					
Help from family/friends					
Other Income not listed Please indicate type					

Other types of income: _____

I declare the above information is true and I grant Muskegon Family Care permission to investigate any information provided in this application. I understand that this information is kept in the strictest confidence. I also understand that should my income change, I am required to notify the receptionist at my next clinic visit.

_____ _____

Signature Date

Do not write below this line. For office use only.

Initial Date: _____ Initial Income Code: _____

Approved/Denied By: _____ Date: _____

SFS Effective Dates: _____-_____ Explanation for denial: _____

Date Patient Informed: _____ How: _____

Informed By: _____ Date: _____ Final Income Code: _____

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