Northeast Michigan Community Mental Health Authority Sliding Fee Discount Program

Northeast Michigan Community Mental Health Authority serves all individuals regardless of ability to pay. Discounts for essential services are offered based on family size and income. For more information call 989-356-2161.

Household/ Family Size	100% Poverty Level*	Monthly Ability to Pay	125% Poverty Level*	Monthly Ability to Pay	150% Poverty Level*	Monthly Ability to Pay	175% Poverty Level*	Monthly Ability to Pay	200% Poverty Level*	Monthly Ability to Pay	300% Poverty Level*	Monthly Ability to Pay	400% Poverty Level*	Monthly Ability to Pay
1	$13,590	$0	$16,988	$14	$20,385	$32	$23,783	$53	$27,180	$95	$40,770	$324	$54,360	$615
2	$18,310	$0	$22,888	$18	$27,465	$45	$32,043	$95	$36,620	$153	$54,930	$510	$73,240	$790.50
3	$23,030	$0	$28,788	$22	$34,545	$62	$40,303	$137	$46,060	$244	$69,090	$676.13	$92,120	$964.00
4	$27,750	$0	$34,688	$27	$41,625	$83	$48,563	$188	$55,500	$324	$83,250	$790.63	$111,000	$1,137.50
5	$32,470	$0	$40,588	$32	$48,705	$108	$56,823	$244	$64,940	$405	$97,410	$905.13	$129,880	$1,311.00
6	$37,190	$0	$46,488	$38	$55,785	$137	$65,083	$324	$74,380	$510	$111,570	$1,019.63	$148,760	$1,484.13
7	$41,910	$0	$52,388	$45	$62,865	$170	$73,343	$384	$83,820	$594	$125,730	$1,134.13	$167,640	$1,658.00
8	$46,630	$0	$58,288	$53	$69,945	$206	$81,603	$447	$93,260	$665.75	$139,890	$1,248.63	$186,520	$1,831.50

For each additional person, add	$4,720	$5,900	$7,080	$8,260	$9,440	$14,160	$18,880
Monthly Ability to pay will increase by	$0	$9-$20/person	$26-$42/person	$40-$84/person	$55.50/person	$114.50/person	$173.50/person

*Based on the 2022 Federal Poverty Guidelines (FPG) for the 48 contiguous states (all states except Alaska and Hawaii).

The amounts listed in the poverty level columns are for annual gross income.

Northeast Michigan Community Mental Health

Financial Determination

IDENTIFYING INFORMATION				
NAME	DOB		CASE #	GENDER
ADDRESS				

RESPONSIBLE PARTY

☐ Patient is responsible to pay bill for charges.

☐ Person other than patient is responsible to pay bill. Please complete Responsible Party information below.

INCOME DOCUMENTATION (INDICATE ALL INCOME DOCUMENTATION PROVIDED BY CONSUMER)

☐ MI Tax Return	☐ Federal Tax Return
☐ Social Security Determination Letter	☐ Unemployment Statement
☐ Bank Statement Showing Direct Deposits	☐ W-2s
☐ Pay Stubs	☐ Other, please specify:

TAXABLE INCOME

A. Based upon Annual Taxable Income

TOTAL ANNUAL TAXABLE INCOME FROM LINE 16 OF MI TAX RETURN

OR

B. Based upon Gross Annual Income less Exemptions

GROSS ANNUAL INCOME

Exemptions:

# OF EXEMPTIONS CLAIMED ON YOUR FEDERAL TAXES OR FAMILY SIZE	x 5000.00
# OF INDIVIDUALS QUALIFYING FOR SPECIAL EXEMPTIONS deaf, blind, or totally and permanently disabled	x 2700.00
# OF QUALIFIED DISABLED VETERANS	x 400.00
TOTAL CALCULATED DEDUCTIONS	
CALCULATED ANNUAL TAXABLE INCOME	

CALCULATED MONTHLY ABILITY TO PAY (ATP)

FEDERAL POVERTY GUIDELINE

FULL FINANCIAL
(Required for all minors and Consumers receving specialized residential services; Optional for non-residential)

FULL FINANCIAL REQUESTED?
☐ Yes ☐ No

ALL FULL FINANCIAL DOCUMENTATION MUST BE SUBMITTED BY

ATP BASED UPON FULL FINANCIAL (COPY AND DOCUMENTATION ATTACHED)

NOTES

FEE DETERMINATION RESULT

EFFECTIVE FROM	EFFECTIVE THRU	MONTHLY MAX CHARGE
BASED UPON	NEXT REVIEW DATE	

NOTES

Insurance Authorization for current or future treatment: This authorization may be cancelled at any time upon request. I hereby authorize Community Mental Health to apply for benefits on my behalf for covered services rendered by them. I also request that all payment from the agreed third party be made directly to them. I hereby certify that all the information that I have provided (including income and insurances) is true to the best of my knowledge. I will report within 14 days of any changes in my income or insurance to the agency. I further authorize the release of any necessary information to the agreed third party for this or related claims. I understand that I will be responsible for any charges incurred by me that are not covered by my insurance up to my ability to pay. Refusal to provide this agency with financial and/or insurance information will result in charging the above mentioned Consumer with the full cost of service.I understand that payment is expected at time of service and that I must make a monthly payment for each calendar month in which service is provided. I understand I have the right to appeal this assessment if I do not agree with it. Also, if my financial situation changes, I can request a new determination with new income documentation at any time. I understand that my ability to pay is based on my proof of income provided within 30 days from the date of my signature. I understand that Northeast Michigan Community Mental Health is required to do an annual update regarding the financial status of my account in accordance with the Michigan Mental Health Code. I will be required to show proof of my gross wages (check stubs, state tax return, W-2 forms, etc.). And, I will need to provide proof of any insurance or Medicaid that I have at that time. I understand that my fee is based on my proof of income provided to Northeast Michigan Community Mental Health each year.

☐ The above has been explained to me and copy provided (if requested).

SIGNATURES

STAFF SIGNATURE / CREDENTIALS _____ DATE _____

CONSUMER SIGNATURE _____ PRINTED NAME _____ DATE _____

ADDITIONAL SIGNATURE / CREDENTIALS _____ DATE _____