**Sliding Fee Program**

**What is the Sliding Fee Program?** The Sliding Fee Program is a federally funded program that provides a discount to patients who are uninsured or underinsured. This program allows qualifying patients to receive Medical, Dental and Behavioral Health services at Upper Great Lakes Family Health Centers (UGL) at a discounted fee after any insurance, if applicable, has processed the claim. There is a minimum amount due at the time of service for all discounted services received.

**Who is eligible for the Sliding Fee Program?** Uninsured and underinsured patients may qualify for the Sliding Fee Program. Patients currently enrolled in other discounted health care programs such as the Western Upper Peninsula Health Access Coalition (WUPHAC), Marquette County Access Coalition or local Charitable Care Programs are encouraged to apply. Federal guidelines require us to take household size and household income into consideration when determining an applicant’s eligibility.

**Where does the Sliding Fee Program apply?** The Sliding Fee Program applies to qualifying patients who receive services at any of these Upper Great Lakes Family Health Center sites:

|  |  |  |
| --- | --- | --- |
| **\*\*Calumet**56720 Calumet Ave.Calumet, MI 49913(906) 483-1177 | **Gwinn**135 East M-35Gwinn, MI 49841(906) 346-9275 | **\*Hancock**500 Campus Dr.Hancock, MI 49930Family Practice (906) 483-1060Pediatrics (906) 483-1700OB/GYN (906) 483-1050 |
| **Houghton**600 MacInnes Dr.Houghton, MI 49931(906) 483-1860 | **Iron River**1500 W. Ice Lake Rd.Iron River, MI 49935(906) 265-5378 | **Lake Linden**945 Ninth St.Lake Linden, MI 49945(906) 483-1030 |
| **Menominee**1110 10th AvenueMenominee, MI 49858(906) 290-5000 | **Ontonagon**751 S. Seventh St.Ontonagon, MI 49953(906) 884-4120 | **\*\*Sawyer**301 Explorer St.Gwinn, MI 49841(906) 346-9275 |

 **Marquette**

 1414 W. Fair Ave, Suite 249

 Marquette, MI 49855

 (906)-449-2900

**\*Hancock Location:** Includes clinic services received in Family Practice, Pediatrics and OB/Gyn.
**\*\*Dental Services** available at these locations; Calumet and Sawyer.

**When should you apply for the Sliding Fee Program?** You should apply immediately to see if you qualify for the Sliding Fee Program. If approved for the program, you will be required to renew your application and information on an annual basis. If you are not approved for the program, you are encouraged to contact us if you have a significant change in income or family size as we may be able to re-evaluate your information.

**How can I apply for the Sliding Fee Program?** You may apply for the Sliding Fee Program by submitting the following:

 \* Completed and signed Sliding Fee Program Application (enclosed)

 \* Proof of Income

 - Income is defined as any money received whether cash, check, or direct deposit used to support your household. Income can include wages, unemployment, pension, social security, disability, child support, gambling winnings and cash payment for services rendered or payment for other reasons.

- Households claiming zero income will be required to provide a signed statement explaining the current financial situation so staff members are able to determine if a discount can be approved.

Enclosed is an application for the Sliding Fee Program. Please complete, sign and return your application and proof of income to the location of your preferred health center above. If you have further questions please contact a Financial Counselor at 906-483-1130 opt. 2. Once received, your completed application will be reviewed by a member of our staff who will then send you a letter regarding your eligibility.

**Please note:** **All of the above information must be received in order to process your application**. Submitting incomplete or partial information will delay a decision until additional requested information is received. Until you receive a letter indicating you have qualified for a discount, you are responsible for 100% of all charges.

Sincerely,

Upper Great Lakes Family Health Center Staff

*Please note: If approved for the Sliding Fee Program,* ***limited*** *Diagnostic and Radiology services are available to you at a discounted rate*

**Sliding Fee Application**

Head of Household \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print) Last Name First Name Middle Initial

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City Zip

Telephone \_\_(\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status Married Single Widowed Separated Divorced

**Household Members**

Please print information below for ALL other persons living in your household

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** | **Date of Birth** | **Relationship** | **Insurance Y/N** |
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|  |   |   |   |
|  |   |   |   |
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|  |   |   |   |

\*Medical Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Dental Insurance Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Income Verification**

Please provide proof of income for all members living within your household. Supporting documentation must show gross pay (total of income before any deductions), cover 4 consecutive weeks of pay and indicate the length of the pay period covered. Examples include:

* + - * + Most Recent Tax Return
				+ Check Stubs
				+ Social Security Income\*
				+ Disability Income
				+ Child Support
				+ Unemployment Income
				+ Pension
				+ Retirement Income

\*If you receive Social Security benefits, please provide the letter you received from the Social Security Administration stating the amount you receive each month. If you are unable to provide the letter, we will accept your last two months of bank statements showing the deposit along with a signed note stating the amount that is taken out for Medicare Part B & D.

**Households claiming zero income will be required to schedule an appointment with a Financial Counselor to determine eligibility.**

I verify that this information presented in this application to be true and accurate to the best of my knowledge and my signature below verifies that I am applying for a Sliding Fee Program discount. Furthermore, I understand that I am responsible for 100% of any charges incurred prior to being deemed eligible to receive a discount through the Sliding Fee Program.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Head of household

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Spouse or other adult household member

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