



Sliding Fee% \_\_\_\_\_ Last Date Reviewed \_\_\_\_\_

# Upper Peninsula Association of Rural Health Services, Inc.

**Northern Menominee Health Center**  
P.O. Box 159, Spalding, MI 49886  
(906) 497-5263 • (800) 270-2905

**Ewen Medical-Dental Center**  
P.O. Box 260, Ewen, MI 49925  
(906) 988-2210 • (800) 270-2904

**West Mackinac Dental Center**  
P.O. Box 249, Engadine, MI 49827  
(906) 477-6090

**Quincy Hill CHC**  
51024 Hwy US 41, Hancock, MI 49930  
(906) 483-2358

**NMHC South**  
805 1st St., Menominee, MI 49858  
(906) 863-2315

**Dickinson-Iron Dental Center**  
211 S. 4th St., Suite B  
Crystal Falls, MI 49920  
(906) 875-6133

**Sawyer Dental Center**  
301 Explorer, Ste. B, Gwinn, MI 49841  
(906) 372-9267

**Marquette/Alger CHC**  
700 West Washington St.  
Marquette, MI 49855  
(906) 228-8238

## APPLICATION FOR SLIDING FEE DISCOUNT

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Have you applied for Medicaid within the last year? (Please check one)  Yes  No

If no, may we make contact for you?  Yes  No

### Household Information

Please list all household member including yourself. Dependents over age 18 will be asked to provide proof of income also or apply separately.

Name	Relationship	Age	Name of medical and/or Dental Insurance on each person	Social Security Number
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Applicant's Employers \_\_\_\_\_ Month/Year Started \_\_\_\_\_

Dependent's Employers \_\_\_\_\_ Month/Year Started \_\_\_\_\_

**Please read the back of this form—A copy of your federal tax return must accompany sliding fee application. If you do not file tax returns we will require other proof of income, (ie) Home Heating Credit claim form.**

### Certification

I hereby certify that all of the information on this form is true and accurate to the best of my knowledge. I will provide available verification or documentation, as requested by the health center. I also understand that this information will be kept confidential and used only by the health center for fee adjustment purposes.

I understand that Sliding Fee patients are required to pay their part of the bill at time of service

\_\_\_\_\_  
Applicant or Authorized Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Office Manager/Reviewer

\_\_\_\_\_  
Date Signed

## Definition

**Income** – Total annual cash receipts *before* taxes from all sources (*including* salaries, public assistance/unemployment/retirement payments, Social Security, child support, etc., but *excluding* gifts, receipts from sale of property or non-cash benefits such as Medicaid, food stamps, public housing, etc.). Loss carry forwards are not considered in the determination of income.

Please send proof of income with your application for sliding fee. Proof of income includes copies of *both* the:

- 1) 2010 federal & state income tax forms. Please include the complete tax form, including schedules A, B, C, D, E, F, Home Heating Credit, Property Tax Credit, etc. as applicable for all family members.
- 2) Current wage, social security, interest, dividend, and other income information. Other income includes the following:

ADC and/or general assistance

Unemployment income

Worker's compensation

Sick/Disability pay

Veteran's benefits

Pensions and annuities

Child support received

Alimony received

Cash work income

Tips

Any other income not mentioned above

Anyone who has no income or negative or unusual income (including business income which is zero or negative) should plan to meet with the office manager to review their application.

Other applicants may be asked to meet with the office manager to explain their income information.

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**Sliding fee will not be approved  
until all information is received**