231.845.6294
www.wmcmhs.org

SLIDING FEE SCALE APPLICATION INSTRUCTION SHEET

The Sliding Fee Scale may give you a discount on services at West Michigan Community Mental Health

- A completed sliding fee scale application and proof of income are required to determine your eligibility for the Sliding Fee Scale Program.
- All information provided will be kept confidential.

STEP 1: Complete Sliding Fee Scale Application

STEP 2: Sign the bottom of the Sliding Fee Scale Application

STEP 3: Submit proof of ALL income for ALL household members over the age of 18.

You must provide one of the following documents for proof of household income:

- Most current Federal Income Tax Return(s)
- Most recent W-2's
- 1 month of most recent household pay-stubs
- Award letters from Social Security and Pensions, Annuities, Trust funds (if applicable) 1 month of most current Unemployment statements or check stubs

**If you are married, you must provide yours and your spouses proof of income.

If you cannot provide one of the above, please include:

- Last 3 months bank statements showing income received

STEP 4: Include your proofs of income with your Sliding Fee Scale Application and mail or drop off at any one of our West Michigan Community Mental Health locations.

Within 30 days, you will receive notice of your Sliding Fee eligibility by mail. Please be sure to sign and return in self-addressed envelope when received.

See back page

Sliding Fee Scale

The Sliding Fee Discount Program is a Federal program that allows West Michigan Community Mental Health to discount our normal charges services provided.

The 2023 Federal Poverty Guidelines will be used for the Sliding Fee Discount Program.

How do I get an application for the Sliding Fee Discount Program?

Sliding Fee Scale packets are located at the front desk of each location. You may also call our Reimbursement Department at 231.845.6294 to request one be sent in the mail.

How is eligibility for the Sliding Fee Discount Program determined?

Eligibility is determined on the household size, annual gross income
(net income for self-employment) for the household, completed application, and proof of income.

Who is considered "household member"?

Household members are related by blood, marriage, or adoption, and legally financially responsible to each other.

How much will I pay if I am approved for the Sliding Fee Discount Program?

The charge for your visit depends on your income, household size, and the type of service you received. When you are approved for the Sliding Fee Discount Program you will receive a letter that details your financial responsibility for services received. Payments are due at the time of service.

WMCMH Reimbursement Specialists are available to answer questions.
Please call 231.845.6294 and ask for the Reimbursement Department.

WMCMH LOCATIONS

Baldwin: 1090 North Michigan Avenue, Baldwin, MI 49304
Hart: 105 Lincoln Street, Hart, MI 49420
Ludington: 920 Diana Street, Ludington, MI 49431

West Michigan CMH
Renew. Rebuild. Recover.™

OFFICE USE ONLY

Return Application by: _____
Date Application Rec'd: _____
Received by Staff (initial): _____

Sliding Fee Scale Application

Consumer Information

Last Name, First Name, Middle Initial:			Case #:
Mailing/Street Address:	City:	State:	Zip Code:
Phone #:	DOB:	Number of people in your household, including yourself:	
If minor responsible party name:_____ DOB:_____ Phone #: _____			

Household Information

Please list all people in your household, related by blood, marriage, or adoption, and financially legally responsible for each other. Eligible household members will be included in your application.

Last Name	First Name	DOB	Relationship to Applicant

Please use back of page for more household members. **Check if you added information on the back of this form** ☐

Types of Income Received by Household

Please place a check (√) in the columns below to indicate *all* sources of income:				
Source of Income	Applicant	Spouse/ Partner	Other	Additional Information
Salary/Wages				
Self-Employment				
Unemployment				
Social Security/Disability				
Pension/Investment (i.e., 401K, IRA, etc.)				
Alimony/Other				

I hereby certify that the information provided on this application is accurate and I authorize West Michigan Community Mental Health to verify any of the information above.

(REQUIRED) Signature of Applicant,
Parent, and/or Legal Guardian: _____ Date: _____

RETURN COMPLETED APPLICATION AND PROOF OF HOUSEHOLD INCOME TO: West Michigan Community Mental Health

Please return via mail in self-addressed envelope, or in person.

***********For Office Use Only***********

Action	**Notes**	**Staff Name and Date**
Verified Household Income		
Verified Number in Household		
Other		
Level/Start Date/End Date **A** **B** **C**		