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 household 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 (see page 2 for family size and household member description)

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.

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)
- **Please note:**
    - If you are married, you must provide your and your spouse's proof of income.
    - If you are applying for a minor and the minor is employed or has any type of income, you are required to provide that income.

STEP 5: Once the attached application is completed and returned with proof of household income, WM will provide notice to you by mail of your application results.

See back page

Sliding Fee Scale FAQ's

What is the Sliding Fee Scale and what is it based on?

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

The 2025 Federal Poverty Guidelines will be used to determine your out-of-pocket cost.

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 by the household size, annual gross income for the household and a completed application.

Who is considered a "family household member"?

Family size means a family unit consisting of the individual, spouse, and dependents.

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

On December 1, 2023, WM is required to implement a per visit co-pay to stay in alignment with the Michigan Administrative Rules. This means your ability-to-pay will be set at a **per visit co-pay** (due at the time of service) with a **monthly maximum.**
For example, if your monthly maximum is calculated at $49 a month, your per visit co-pay will be $15 per visit but will not exceed your $49 monthly maximum. You will pay $15 per visit but no more than $49 a month.

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

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 family size, including yourself:**	

If minor responsible party name:_____ DOB:_____ Phone #: _____

Family Household Size Information

Please list all the people in your family. Family size means a family unit consisting of the individual, spouse, and dependents.

Last Name	First Name	DOB	Relationship to Applicant

****WM will only use eligible members in determining your application results.**

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 as of this date and I authorize West Michigan Community Mental Health to verify any of the information above. I acknowledge that if I have a significant change in household income, I am required to report those changes to re-determine my eligibility.

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

*****Unsigned applications will not be accepted and will be returned.**

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