Client Section:

CLIENT'S NAME: _____

CLIENT'S SOCIAL SECURITY NUMBER: _____

NAME OF PROGRAM & LOCATION: _____

I understand that a portion of the cost of my treatment may be subsidized by public funds, if necessary. Eligibility is determined by application of the Lakeshore Regional Partners (LRP) sliding fee scale. As required by eligibility guidelines, I hereby declare that my current personal income before taxes is $_____ per year and that my current total household income before taxes is $_____ per year. My family size is _____ dependents, including myself. Of these dependents, _____ qualify for a special exemption (deaf, blind, hemiplegic, paraplegic, quadriplegic, or totally and permanently disabled) and _____(#) qualify as a disabled veteran. Based on this information and applying the LRP sliding fee scale, it has been determined that my share will be $_____ per month.

Insurance Statement: I ☐ **am**/☐ **am not** covered by a health insurance plan. If yes, the name of my insurance company or plan is _____.

If I have health insurance through Michigan Blue Cross/Blue Shield, Medicare, Medicaid, Healthy Michigan Program, MIChild, an HMO, or other third party, I authorize the treatment provider to bill my insurance company and request that any payments from insurance be made directly to the treatment provider. I certify that the information given by me to the treatment provider concerning my insurance is correct.

I attest and verify that all information herein provided is true and accurate. I understand that inaccurate information provided could result in my being financially responsible for the full cost of the care I received. I further understand that it is my responsibility to inform this program of any change in my income, employment or insurance status, or number of dependents.

Client's Signature: _____ Date: _____

LAKESHORE REGIONAL PARTNERS

Provider Section:

Adjustments from the standard fee schedule must have prior approval. Documentation of approval must be maintained in the case record.

Income verification provided via: (continued on page 2)

☐Current Payroll Stub (in last 3 weeks)

☐Unemployment Pay Stub

☐State or Federal Income Tax Form (i.e. IRS form 1040)

☐Workers Compensation record

☐Social Security income record

☐Other (Describe): _____

Please attach copy of verification.

Income verification not provided because:

☐Minor in treatment without parental knowledge

☐Other (Describe): _____

If client is uninsured has he/she applied for Michigan Medicaid or Healthy Michigan Program benefits?

☐Yes ☐No ☐Not Applicable

If yes, indicate date: _____

If no, indicate why: _____

If client is claiming no or very low income, please describe how his/her current housing, food, and other needs are being met._____

Program Staff Signature: _____ Date: _____

Program Staff Name (Print): _____

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