Macomb County Community Mental Health

FOCUS

Financial Determination

IDENTIFYING INFORMATION		
NAME:	**CASE NUMBER:**	**MEDICAID ID:**
DOB:	**GENDER:**	
ADDRESS:		

FUNDING SOURCE: SELF-PAY

MEDICAID ID #: _____ **MI CHILD #:**_____

IS MEDICAID/ABW CURRENTLY ACTIVE? ☐ **Yes** ☐ **No**

IS MI CHILD CURRENTLY ACTIVE? ☐ **Yes** ☐ **No**

TOTAL ANNUAL HOUSEHOLD INCOME (NOT USED IN FEE CALCULATION): ☐

NO. OF DEPENDENTS: ☐

INCOME DOCUMENTATION

- ☐ MI Tax Return
- ☐ Social Security Determination Letter
- ☐ Bank Statement Showing Direct Deposits
- ☐ Pay Stubs
- ☐ Federal Tax Return
- ☐ Unemployment Statement
- ☐ W-2s
- ☐ Other, Explain:_____

NON-TAXABLE INCOME

DHS: _____ **SOCIAL SECURITY:**_____ **CHILD SUPPORT:**_____

OTHER: _____ **SPECIFY OTHER SOURCE(S):**_____

TAXABLE INCOME & SLIDING FEE CALCULATION (Non-residential services)

Based upon Either Line 16 of MI1040 or Gross Annual Income Less Exemptions

1.Line 16 of the MI1040 (do not include exemptions)			**$**
			OR
2.a Gross Annual Income (do not include non-taxable income)			**$**
2.b # of Exemptions Claimed on your Federal Taxes	**#:**	**X 3,763.00**	**=**
2.c # of individuals qualifying for special exemptions	**#:**	**X 2,400.00**	**=**
2.d # of qualified disabled veterans	**#:**	**X 300.00**	**=**
2.e (= 2.b + 2.c + 2.d)			**$**
2.f (= 2.a – 2.e)			**$**
Calculated Monthly Ability To Pay (ATP) based on either Line 1 or 2.f matched to the Sliding Fee Schedule (see FOCUS documents)			**$**

Full Financial Requested:_____

All full-financial documentation must be submitted by this date:_____

FEE DETERMINATION RESULT

Effective From: _____ **Effective Thru:** _____ **Monthly Maximum Charge:** _____

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RESPONSIBLE PARTY

☐ **PATIENT IS RESPONSIBLE TO PAY BILL FOR CHARGES.**

☐ **PARENT OR GUARDIAN CONTACT INFORMATION:**

_____

_____

_____

NOTES

RESPONSIBLE FINANCIAL PARTY SIGNATURES

A FINANCIAL REVIEW AND REDETERMINATION WILL OCCUR SHOULD MEDICAID, ABW, or MI CHILD ELIGIBILITY LAPSE.

In accordance with the Michigan Mental Health Code and Michigan Department of Community Mental Health (MDCH) Rules & Procedures, all MCCMH consumers, except those with full Medicaid, ABW, or MI Child eligibility, are assessed a monthly maximum charge based upon the MDCH Sliding Fee Scale or Full Financial Review, regardless of Medicare or Insurance coverage.

The provider must be notified of any financial, insurance, or eligibility changes during the course of treatment and re-determine the fee accordingly. The Responsible Party may also request a redetermination during the course of treatment.

When the Responsible Party willfully fails to provide information necessary to apply for or secure insurance that covers, in part or in whole, the cost of services provided, the ability to pay/monthly maximum charge of the Responsible Party shall be determined to be the full cost of services.

My signature documents that all information I have provided is accurate and complete. Further, I acknowledge that this Fee Agreement has been explained to me and I understand how the Monthly Maximum Charge was calculated.

_____ _____

Consumer Signature (if applicable) & Date **Witness Signature (if applicable) & Date**

_____ _____

Guardian/Parent Signature (if applicable) & Date **Preparer's Signature & Date**