Grace Health

Sliding Fee Discount Application

Patient Name _____ Date of Birth _____

Address _____
(Street) (Apt./Lot) (City) (Zip Code)

Telephone Number _____

Do you receive income? ❑ Yes ❑ No **Documentation required for all applications.**

Please list all persons living at the above address (*additional names may be listed on other side*)

Full Name	Relationship to Applicant	Date of Birth	Patient of Grace Health *(please ✓one)*		Income *(please ✓one)*	
			Yes	No	Yes	No
			❑	❑	❑	❑
			❑	❑	❑	❑
			❑	❑	❑	❑
			❑	❑	❑	❑

Number of people in household _____ (*may be different than number of family members*)

Health Insurance: ❑ Blue Cross ❑ Medicare ❑ Medicaid ❑ Other ❑ None

Name of insurance: _____

Do you have dental/vision insurance? ❑ Yes ❑ No

Name of insurance(s): _____

The above information is correct to the best of my knowledge. I understand that it is my responsibility to pay the fee established according to my household income and family size. I agree to notify Grace Health within 30 days of any change in my income. I understand that if I provide false information or withhold financial income, I will be disqualified from the discount program.

Signature _____ Date _____

_____ **I hereby give my permission for Grace Health to release this application along with my financial information to Bronson Battle Creek lab located within Grace Health.**
(initial)

Please Read

This discount program is made available by a grant from the US Department of Health and Human Services. The schedule of discounts is available for review upon request. Applications will be reviewed by Grace Health annually.

A completed application must include your proof of income. Application and income information can be emailed to patientfinancialservices@gracehealthmi.org. Please call 269-441-3456 if you need assistance.

For Office Use Only

Documents to be Returned:

Application Completed	Date	Initials	Proof of Income	Date	Initials
UDS Completed			❑ requested		
Adjustment Applied			❑ received		
Annual Income:			Monthly Income:		
Eligibility determined at Category: ❑ A ❑ B ❑ C ❑ D					
Start Date:			Expiration Date:		