SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

989-797-3400
www.sccmha.org

ABILITY TO PAY/SLIDING FEE SCALE APPLICATION INSTRUCTION SHEET

If you are not currently enrolled In Medicaid or Healthy Michigan, the Sliding Fee Scale may give you a discount on services at Saginaw County Community Mental Health.

- A completed Ability to Pay/Sliding Fee Scale Application is a requirement of the Michigan Mental Health Code at admission, annually, and if income or insurance changes.
- If you are uninsured/non-Medicaid eligible, household information and proof of income are required to determine your eligibility for the Ability to Pay/Sliding Fee Scale Program.
- If you have Medicaid, your ability to pay/sliding fee amount for CMH (community mental health) services is $0 (zero), however, you are still required to provide insurance information.
- All information provided will be kept confidential.

STEP 1: Complete Ability to Pay/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 (uninsured/non-Medicaid only)

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 spouse's 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 Ability to Pay/Sliding Fee Scale Application and mail or drop off at Saginaw County Community Mental Health, Entitlements Office.

Within 7 days, if you are uninsured, you will receive notice of your Ability to Pay/Sliding Fee eligibility by mail. Note: If you have Medicaid your ability to pay/sliding fee amount is $0 (zero)

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SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

Ability to Pay/Sliding Fee Scale

The Ability to Pay/Sliding Fee Discount Program is a Federal program that allows Saginaw County Community Mental Health to discount our normal charges on 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?

Ability to Pay/Sliding Fee Scale packets are located at the front desk of each location. You may also call our Entitlements Office 989-272-7340 or 989-272-0242 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 a “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 Ability to Pay/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. A monthly bill/invoice will be sent.

If you have Medicaid, your ability to pay/sliding fee scale amount is $0 (zero)

SCCMHA Entitlement Coordinators are available to answer questions.

Please call 989-272-7340 or 989-272-0242

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

OFFICE USE ONLY

Return Application by: _____

Date Application Rec'd: _____

Received by Staff (initial): _____

Ability to Pay/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 #: _____			

Insurance Information (attach copy of card(s)–front/back)

Please list all current insurance policies, including Medicaid, Medicare, and Commercial Coverage.

Insurance Company Name	Contract/Policy #	Group #	Effective Date	Policy Holder Name/Date of Birth

If you have active Medicaid, your Ability to Pay/Sliding Fee Scale amount is $0 (zero), please skip the following household and income questions, and sign/date.

Household Information (uninsured/non-Medicaid only)

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

Consumer Name	Case #

Types of Income Received by Household (uninsured/non-Medicaid only)

Please place a check (√) in the columns below to indicate *all* sources of income:				
Source of Income	Applicant	Spouse/ Partner	Other	Amount of Annual Income * attach proof
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 Saginaw County Community Mental Health Authority to verify any of the information above.

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

RETURN COMPLETED APPLICATION, PROOF OF HOUSEHOLD INCOME (uninsured) and copy of insurance card(s) TO:
Saginaw County Community Mental Health
Entitlements Office
500 Hancock
Saginaw MI 48602

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

Action	Notes	Staff Initials and Date
Verified Active Medicaid/Non-Medicaid		
Verified Household Income		
Verified Number in Household		
Other		
Level **A B C** **Amount Per Visit/Day**	**Start Date**	**End Date**

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

Saginaw County Community Mental Health Authority
Sliding Fee Scale

Sliding Fee Category Code	A	B	C
Client Responsibility Per Visit	$ 0 / Per Day	$ 10 / Per Day	$ 20 / Per Day
% of Poverty	0% - 133%	134% - 200%	200% +

Family Size Income	Above	Below	Above	Below	Above	
1	$0	$19,391	$19,392	$29,159	$29,160	
2	$0	$26,228	$26,229	$39,439	$39,440	
3	$0	$33,064	$33,065	$49,719	$49,720	
4	$0	$39,900	$39,901	$59,999	$60,000	
5	$0	$46,736	$46,737	$70,279	$70,280	
6	$0	$53,572	$53,573	$80,559	$80,560	
7	$0	$60,409	$60,410	$90,839	$90,840	
8	$0	$67,245	$67,246	$101,119	$101,120	

Add $6,836 for each additional person over 8

(Calculations are based on the 2023 Federal Poverty Guidelines as Approved Jan. 12, 2023)

This copy can be kept for your records.