



## Sliding Fee Discount Plan

Thunder Bay Community Health Service provides services regardless of the individual's ability to pay. For qualification, patients must provide a completed application and proof of gross income. Proof of income examples include, but are not limited to, recent pay stubs, Social Security Income (Medicare Award Letter), Federal or Michigan 1040 Forms, W-2 Forms, Proof of Pension, Unemployment Determination, or a letter from a friend or family member that is providing support if there is no income to show. Upon approval, the discount will be honored for one year from the date of application. Patients must reapply annually. Discounts are offered based on family size and income and could result in a nominal amount due of \$10.00 for medical or behavioral health services, \$30.00 for dental services, \$45.00 for optical lenses and frames, and \$3.00 per prescription plus the cost of dispensing the medication. Assistance for insurance enrollment will be provided for eligible patients. The nominal payment is expected at the time of service.

### Services Covered and Excluded

**Professional Services:** Discounts apply to all in-office professional services. Services not eligible for a discount include select medical supplies or upgrades to optical lenses/frames or upgrades to dental appliances or the pharmacy dispensing fee. The nominal fee may not apply to all dental services.

**Referred Care:** Discounts do not apply to out-of-office referred care, such as referrals to specialists and the emergency room, and testing, such as X-rays, CT scans, MRIs, and pathology.

**Lab:** Discounts apply to in-office charges for laboratory services. Lab tests referred to Quest Laboratory qualify for discount.



# Thunder Bay

COMMUNITY HEALTH SERVICE, INC.

## Discount Plan Application

Patient/Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

(City)

(State)

(Zip)

Telephone: \_\_\_\_\_ Employer: \_\_\_\_\_

Self / Spouse / Dependents Under Age 18	Relationship	Date of Birth	All gross earnings Weekly or Monthly or Annual

### Proof of income is required for earnings listed

Do you have medical insurance? (Please list) \_\_\_\_\_

Do you have dental insurance? (Please list) \_\_\_\_\_

We assist the uninsured and underinsured obtain health insurance. Would you like us to contact you about this? Yes  No

I certify that the information listed above is true and accurate and that I have no other income not listed. I understand that the information listed is subject to review by federal and/or state enforcement agencies or others as required.

Signature

Date

For Office Use Only:

Effective Date \_\_\_\_\_

Recertification Date \_\_\_\_\_

Initials \_\_\_\_\_

Approved Discount Rate:

	Medical	Dental	Optometry	Rx
<input type="checkbox"/> Tier 1 - ZA	\$10.00	\$30.00	\$45.00	\$3.00-10.00
<input type="checkbox"/> Tier 2 - ZB	\$30.00	40%	\$50.00	\$5.00-12.00
<input type="checkbox"/> Tier 3 - ZC	\$55.00	50%	\$60.00	\$7.00-14.00
<input type="checkbox"/> Tier 4 - ZD	\$85.00	60%	\$65.00	\$9.00-16.00

Overqualified