Sliding Fee
Discount Application

Elmhurst Home, Inc.
"Recovery with Dignity"

Elmhurst Home Inc. is a CCBHC agency that is able to offer a discount on certain services based on a household's income and size. Sliding fee calculations are determined by using an applicant's total household annual income and are based on the most recent Federal Poverty Guidelines (table displayed on reverse side) to determine your eligibility.

If you wish to qualify for the sliding fee, you must show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please provide a brief, written statement explaining how you provide basic life essentials, food, and shelter.

Applicants should provide a copy of the following documents, if applicable:

- Previous year's Federal Tax Return, W-2's or 1099's (Income will come from total income line)
- Most recent pay stubs spanning four weeks
- Social Security or Pension Income
- Public assistance award letters for each adult age 18 and over living in the household.
- Unemployment compensation

Your household discount will be assessed once per year. You must reapply for the Sliding Fee discount and provide updated income documentation at this time.

PLEASE NOTE: You may be responsible for the payment of some procedures, labs, and medications. If you have any questions, please contact the EHI Billing Department at 313-867-1002.

Return completed application(s) and income documentation within 21 days to EHI administration:
Elmhurst Home Inc. , Attn: Billing Department, 12010 Linwood St, Detroit, MI 48206

Name: _____ Date of Birth: _____

Family Size (number of family members living in your household):

List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible:

_____

_____

_____

Address: _____

Phone: _____ Do you have insurance? YES NO

If yes, please provide: Medical Plan Name: _____

Dental Plan Name: _____

DISCLAIMER: I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify The Elmhurst Home Inc. of any changes in this information within ten (10) days of such change.

I understand that I must re-qualify annually to maintain my eligibility.

I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service. To maintain discount, fees must be paid promptly. If you are unable to make payment at time of service, please contact the EHI Billing Department at 313-867-1002 to make other payment arrangements.

_____ _____

Signature **Date**

FOR INTERNAL USE ONLY

Annual Gross Income _____

Patient is eligible for sliding fee discount category _____

Proof of income verified
Patient refused to complete
Patient does not qualify for sliding fee

_____

Verified by Date

2023 EHI Sliding Fee Scale - Behavioral Health

All questions should be answered; those not applicable must be marked with N/A

I understand that a portion of the cost of services provided to me is being subsidized by public funds. As required by eligibility guidelines, I hereby certify that my personal and household income for the past 12 months was $ _____.

I further understand that and agree that this amount and the dates that I receive service may be subject to further verification by DWMHA or its treatment contractors. Additionally, this information will be reviewed every 90 days after admission to treatment.

I understand that the co-payment portion of my service cost is my responsibility to pay.

_____ _____

Print Client Name Date

_____

Client Signature

_____ _____

Print Client Name Date

_____

Witness Signature

Sliding Fee Scale
Based on Federal Register 2023
Poverty Guidelines

Family Size	Income Measure	Category 0	Category 1	Category 2	Category 3	Category 4
% of Federal Poverty Income Level		Up to 100%	100.01%-149.99%	150.00%-174.99%	175.00%-199.99%	200.00%+
		Patient Fee: $5.00	Patient Fee: $10.00	Patient Fee: $20.00	Patient Fee: $30.00	Patient Fee: 100%
1	Annual Monthly Weekly	$14,580 $1,215 $280.38	$29,160.00 $2,430.00 $560.77	$43,740.00 $3,645.00 $841.15	$58,320.00 $4,860.00 $1,121.54	$58,321.00 $4,860.08 $1,121.56
2	Annual Monthly Weekly	$19,720.00 $1,643.33 $379.23	$39,440.00 $3,286.67 $758.46	$59,160.00 $4,930.00 $1,137.69	$78,880.00 $6,573.33 $1,516.92	$78,881.00 $6,573.42 $1,516.94
3	Annual Monthly Weekly	$24,860.00 $2,071.67 $478.08	$49,720.00 $4,143.33 $956.15	$74,580.00 $6,215.00 $1,434.23	$99,440.00 $8,286.67 $1,912.31	$99,441.00 $8,286.75 $1,912.33
4	Annual Monthly Weekly	$30,000.00 $2,500.00 $576.92	$60,000.00 $5,000.00 $1,153.85	$90,000.00 $7,500.00 $1,730.77	$120,000.00 $10,000.00 $2,307.69	$120,001.00 $10,000.08 $2,307.71
5	Annual Monthly Weekly	$35,140.00 $2,928.33 $675.77	$70,280.00 $5,856.67 $1351.54	$105,420.00 $8,785.00 $2,027.31	$140,560.00 $11,713.33 $2,703.08	$140,561.00 $11,713.42 $2,703.10
6	Annual Monthly Weekly	$40,280.00 $3,356.67 $774.62	$80,560.00 $6,713.33 $1,549.23	$120,840.00 $10,070.00 $2,323.85	$161,120.00 $13,426.67 $3,098.46	$161,121.00 $13,426.75 $3,098.48
7	Annual Monthly Weekly	$45,420.00 $3,785.00 $873.46	$90,840.00 $7,570.00 $1,746.92	$136,260.00 $11,355.00 $2,620.38	$181.680.00 $15,140.00 $3,493.85	$181,681.00 $15,140.08 $3,493.87
8	Annual Monthly Weekly	$50,560.00 $4,213.33 $972.31	$101,120.00 $8,426.67 $1,944.62	$151,680.00 $12,640.00 $2,916.92	$202,240.00 $16,853.33 $3,889.23	$202,241.00 $16,853.42 $3,889.25
Each additional family member	Annual Monthly Weekly	$5,140.00 $428.33 $98.85	$10,280.00 $856.67 $197.69	$15,420.00 $1,285.00 $296.54	$20,560.00 $1,713.33 $395.38	$20,560.00 $1,713.33 $395.38

EXCLUSIONS - CATEGORY 0

Behavioral Health & SUD Treatments

The following will be billed at 100% of EHI's actual costs:

- Injectables
- Residential Treatment

EXCLUSIONS - CATEGORY 1-3

Behavioral Health & SUD Treatments

The following will be billed at 100% of EHI's actual costs:

- Certain Injectables
- Residential Treatment

Based on poverty guidelines, starts at 100% and goes up in 25% increments
Highest level is 225% of poverty guidelines

Allows Access staff to make adjustments in co-pay amounts for special circumstances (reduce up to 30%; no adjustment to income or over 30% of copay without supervisory approval)

Client Signature

Your Cost of Treatment is $_____ Copy Received by _____

Date: _____ /_____ / _____

DETROIT WAYNE MENTAL HEALTH AUTHORITY (DWMHA)

DETERMINATION OF ELIGIBILITY WORKSHEET

Program Name: Elmhurst Home, Inc.

1. INCOME
(Use Annual Income figures, rounded to the nearest whole dollar)

Client's Earned Income: 1. $ _____

Add (where applicable):

Spouse (cohabitant) Income: 2. $ _____

(If minor living with parents)
Father/ Guardian Income: 3. $_____

Mother/ Guardian Income: 4. $_____

TOTAL EARNED INCOME: 5. $_____
(Add lines 1 thru 4)

ADD: Additions to Income:
(i.e., SSI, SSDI, Unemployment,
Workers Compensation, Child Support)
Specify: 6a. $_____

6b. $_____

SUBTOTAL:
(Add lines 5 thru 6b) 7. $_____

DEDUCT: Child Support paid for
(Children not claimed as dependents)
On Income Tax Forms 8. $_____

Adjusted Annual Income: 9. $_____

2. DEPENDENTS:

Number of children living in the home
(Include client if minor) 10. $_____

(Number of children not living in the home)
But claimed as dependents on income
Tax Forms: 11. $_____

TOTAL DEPENDENTS: (Add Lines 10 & 11) 12. $_____

3. ABILITY TO PAY:

Cost per unit of service (treatment day, individual, Group, etc.) 13. $_____

%Rate Obligation to pay: (on Federal Fee Scale) 14. $_____

Client's Cash Obligation (unit cost x % rate) 15. $_____

(If 15 is less than $1.00 enter $1.00 on line 16) 16. $_____

Expected number of treatment/s Unit/s: 17. $_____

Total Client Obligation (16 x 17) 18. $_____

This is a preliminary agreement. The provider may revise this agreement if changes occur in the client's financial status.

The undersigned client certifies the above income and family information to be true and understands that providing false information constitutes fraud.

The client is responsible for paying the client portion of the treatment cost as shown on line 18.

The identified client obligation may be waived by the AMS if the provider provides justification that the identified amount will cause the client undue financial hardship. The AMS will review all pertinent information. See attached Waiver of Client Financial Ability to Pay For services.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

_____ _____

Witness Signature Date

Elmhurst Home, Inc.

PROVIDER NAME: _____