230 W Oak Street - Fremont, MI 49412

Pine Medical Group offers different payment options for our uninsured patients.

- **Prompt pay discount - 25% discount for payment at the time of service for most charges.**
- **Pine Medical Group charges incurred at Gerber Memorial Hospital will receive a 25% discount if paid within the first statement cycle.**
- **Payment plan options.**
- **Assistance in applying for Medicaid.**
- **Financial Relief through our Sliding Fee Program.**

I have enclosed an application for Pine Medical's Sliding fee program. Once completed, you will need to schedule an appointment with the Patient Advocate to review your application. Our program is based on income, expenses and the number of people in your household. We process the information in comparison to the national poverty levels and qualify individuals on a standard qualification table. This program may help cover some of your expenses incurred with Pine Medical Group, P.C.

When completing the application please include all income, asset and expense information for everyone that lives within the home. It is necessary to send verification of income with your application as we are unable to process it without the proof of income. Verification of income would include any of the following: a copy of your most recent tax return, W-2, paycheck stubs (2) or your last financial notification from the Social Security office.

Please call our office at (231)924-4200 to schedule an appointment once the application has been completed

Thank you,

Stephanie Grell
Patient Advocate
sgrell@pinemed.com

Pine Medical Group, P.C. 230 West Oak St. Fremont, MI 49412 231-924-4200

Medicaid Questionnaire

This is to see if you are eligible for Medicaid. This will not disqualify you from the Sliding Fee Scale program.

Name ______________________ **Account#** ______________
Address____
City___________________ **State**________ **Zip** ______________

Please answer the following questions

	Yes	No
Are you under 21 years old?	( )	( )
Are you pregnant?	( )	( )
Are you 65 years or older?	( )	( )
Do you have any of your children/dependents living with you, that are under 18 years old ?	( )	( )
Do you receive Social Security Disability ?	( )	( )
Are you legally blind?	( )	( )

How long are you expected to be unable to work? ______________________

If all of the above answers are marked "no" you would not be eligible for Medicaid, and do not have to fill out the Medicaid application. If all no, gin and return to Pine Medical Group, P.C.

If any are marked yes, you must complete an application for Medicaid or go you your local Department of Human Services, before any decisions are made for the sliding fee scale.

You still have the right to apply for Medicaid if you think you may still be eligible.

Signature of Patient ______________________________

Date____________________

Sliding Fee Scale Application

Confidential Financial Statement: I understand that the information which I submit concerning my annual income, family size, and assets is subject to verification by Pine Medical Group, P.C. I also understand that if the information which I submit is determined to be false, such a determination may result in a rejection of this application, and that the balance owing is due and payable immediately.

Name:____Phone:______________
First M.I. Last (area code) Phone#

Address:____
Number, street, PO Box City State Zip

How long have you lived at this address?____________________________________

Date you applied for Medicaid:	Case worker's name:
Your occupation:	Your spouse's name:
Social Security number:	Spouse's occupation:
Employer: How long?	Spouse's Social Security number:
Address:	Spouse's employer: How long?
Previous employer: How long?	Address:

Family unit (circle one): married widow single divorced

Dependents' Names	Age	Relationship

HOUSEHOLD INCOME for the last *12 months* (please list in dollar amounts):	
Wages: $	Rate: $
Farm or self-employment: $	
Public assistance: $	
Social Security: $	
Unemployment compensation: $	
Strike benefits: $	
Alimony: $	
Child support: $	
Military family allotments: $	

(annual household income continued…)
Pensions: $
Income from Dividend, interest, IRAs: $
Scholarships or grants: $
Rental Income: $

ASSETS:	
Financial Institution:	**List approximate market value:**
	Home (assessed value): $
	Cash/Checking accts: $
	Savings acct: $
	Stocks/bonds: $
	Whole Life Insurance: $

AUTOMOBILES:		OTHER:	
Year & Model:	**Value:**	**Year & Model:**	**Value:**
	$	Motorcycles:	$
	$	Watercrafts:	$
	$	Snowmobiles:	$
	$	Trailers:	$

MONTHLY CREDIT PAYMENTS:	Sears: $
Visa: $	JC Penney: $
Master Card: $	Other: $
Discover: $	Other: $

MONTHLY HOUSEHOLD EXPENSES:	Electricity: $
House/Rent: $	Landline telephone: $
Home insurance: $	Cellular telephones: $
Health insurance: $	Water/sewer: $
Property taxes: $	Auto payment: $
Groceries: $	Auto payment: $
Cable/Satellite TV: $	Auto insurance: $
Propane/Gas: $	Fuel for autos: $
Daycare/Preschool: $	
OTHER LOANS/ Banks, Medical, etc.:	**Institution:**
$	
$	
$	

Please tell us how you heard about our Sliding Fee Scale program:

___review ___friend ___other:

___staff ___Health Department

STATEMENT OF UNDERSTANDING:

I understand the application for the patient Sliding Fee Scale will be reviewed annually to determine my eligibility. I understand that any change in income must be reported to Pine Medical Group's billing department within thirty (30) days, and I attest that this statement of my family/household income is true and accurate to the best of my knowledge. All statements I have provided on this application are true.

I understand that the information I have provided is subject to verification by Pine Medical Group and is subject to review of federal and/or state enforcement agencies and others as required.

____ ________________________
Signature of person making request Date

Please provide copies of:

- Your driver's license or other legal photo identification AND ONE OF THE FOLLOWING:
- Your two (2) most recent pay stub(s), OR
- a copy of your most recent W-2/tax return

Prior to determination of eligibility, it is possible we may also ask for copies of utility bills to verify proof of residence and obligation.

Return this application and required items (listed above) to:

Pine Medical Group, P.C.
Attn: Patient Advocate
230 W. Oak Street
Fremont MI 49412

Phone: 231-924-6708, option 4, then option 7
Fax: 231-924-1635

FOR OFFICE USE ONLY:

_____ Approved
_____ Denied

Approval begin date:__________________

End date:____________________

____ ________________________
Signature of Patient Advocate Date