COMMUNITY MENTAL HEALTH & SUBSTANCE ABUSE SERVICES OF ST. JOSEPH COUNTY

**CMHSAS-STJ**

**Financial Determination**

| IDENTIFYING INFORMATION | | | | |
|---|---|---|---|---|
| NAME | DOB | | CASE # | GENDER |
| ADDRESS | | | | |

**RESPONSIBLE PARTY**

☐ Patient is responsible to pay bill for charges.

☐ Person other than patient is responsible to pay bill. Please complete Responsible Party information below.

MEDICAID ID #

IS MEDICAID / HEALTHY MICHIGAN PLAN CURRENTLY ACTIVE?
☐ Yes ☐ No

NOTES

☐ Zero Fee Based on Insurance (Medicaid, HMP or MIChild) or qualifying programs.
☐ Fee Based on Income or Specialized Residential

| FEE DETERMINATION RESULT | | |
|---|---|---|
| EFFECTIVE FROM | EFFECTIVE THRU | MONTHLY MAX CHARGE |
| BASED UPON | NEXT REVIEW DATE | |
| NOTES | | |

**Insurance Authorization for current or future treatment:** This authorization may be cancelled at any time upon request. I hereby authorize CMHSAS-STJ to apply for benefits on my behalf for covered services rendered by them. I also request that all payment from the agreed third party be made directly to them. I hereby certify that all the information that I have provided (including income and insurances) is true to the best of my knowledge. I will report within 14 days of any changes in my income or insurance to the agency. I further authorize the release of any necessary information to the agreed third party for this or related claims. I understand that I will be responsible for any charges incurred by me that are not covered by my insurance up to my ability to pay. Refusal to provide this agency with financial and/or insurance information will result in charging the above mentioned Client with the full cost of service.I understand that payment is expected at time of service and that I must make a monthly payment for each calendar month in which service is provided. I understand I have the right to appeal this assessment if I do not agree with it.Also, if my financial situation changes, I can request a new determination with new income documentation at any time. I understand that my ability to pay is based on my proof of income provided within 30 days from the date of my signature. I understand that CMHSAS-STJ is required to do an annual update regarding the financial status of my account in accordance with the Michigan Mental Health Code. I will be required to show proof of my gross wages (check stubs, state tax return, W-2 forms, etc.). And, I will need to provide proof of any insurance or Medicaid that I have at that time. I understand that my fee is based on my proof of income provided to CMHSAS-STJ each year.

☐ The above has been explained to me and copy provided (if requested).

## SIGNATURES

STAFF SIGNATURE / CREDENTIALS

DATE

CLIENT SIGNATURE

PRINTED NAME

DATE

ADDITIONAL SIGNATURE / CREDENTIALS

DATE

STJSTJFDA000000000