NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY #

FINANCIAL DETERMINATION - ABILITY TO PAY

CONSUMER - FIRST M.I. LAST			ADDRESS	CITY	STATE	ZIP
*********	**SOCIAL SEC. NO**	PHONE OK to call? **Y**☐ **N**☐	CTY NO	TWP NO	**MARITAL STATUS** : ☐ SINGLE ☐ MAR. ☐ SEP. ☐ DIV. ☐ WID	
EDUC.	PREVIOUS MH SERVICES ☐Yes ☐No	OTHER FAMILY MBRS RECEIVING CMH SERVICES ☐Yes ☐No		PARENT/GUARDIAN / SPOUSE / NEXT OF KIN / STEP PARENT		
RESPONSIBLE PARTY – FIRST MI LAST			ADDRESS	CITY	STATE ZIP	PHONE
FAMILY PHYSICIAN	**REFFERRED BY**:		DOB	***Place of Birth: City/State**		
PRIMARY INSURANCE	**SUBSCRIBER NAME**	SOCIAL SEC. NO.	DOB	POLICY // GROUP // CONTRACT #	EMPLOYER	
SECONDARY INS.	**SUBSCRIBER NAME**	SOCIAL SEC. NO.	DOB	POLICY // GROUP // CONTRACT #	EMPLOYER	
TERTIARY INSURANCE	**SUBSCRIBER NAME**	SOCIAL SEC. NO.	DOB	POLICY // GROUP // CONTRACT #	EMPLOYER	

Determination Type: ☐ Initial ☐ Annual ☐ New ☐ Redetermination For: ☐ Inpatient ☐ Residential ☐ Outpatient

Determination For: ☐ Individual Only ☐ Individual/Spouse ☐ Child ☐ Parents ☐ Father ☐ Mother

Does minor have INCOME: ☐ yes ☐ no Does minor have ASSETS: ☐ yes ☐ no

DID YOU FILE A MICHIGAN INCOME TAX RETURN? ☐ YES ☐ NO. IF YES indicate line 16 $_____of MICHIGAN RETURN

BELOW GROSS INCOME/EARNED-UNEARNED		**1.** TOTAL GROSS ANNUAL INCOME		**NOTES**
YOUR EMPLOYER-Min wageY☐ N☐		**2.** PROTECTED INCOME **residential only**		FIA telephone #'s
SPOUSE EMPLOYER-Min wage Y☐ N☐		individual (67 MO) = $684 yr ** (64 MO) = $ 768 yr ***		Alcona (989) 724-6291
UNEMPLOYMENT/WORKMANS COMP		**NET ANNUAL INCOME**		Alpena (989) 354-7200
SICK PAY/LONG TERM DISBL. INCOME		**3.** ASSETS		Montmorency (989) 785-4218
FOOD STAMPS		REAL & PERSONAL (boat, 2nd car, vacation home,etc)		Presque Isle (989) 734-2108
FIP GRANT/ DISABLIITY ASSIST. THRU FIA		BANK ACCOUNTS // CASH		
RETIREMENT, PENSION & TAX SHELTERED		STOCK/BONDS/OTHER SAVINGS		Do we have your permission to contact you after discharge
VETERANS		OTHER (e.g.,CDs,401K, IRA,TRUSTS)		to participate in a survey
SOCIAL SECURITY / S.S.I.		**TOTAL AVAILABLE ASSETS**		YES NO
SOCIAL SECURITY DISABILITY		**4.** PROTECTED ASSETS (see below)		
ALIMONY / CHILD SUPPORT		Individual $2000		
ADOPTION SUBSIDY		Individual & dependent $3000		
RENTAL INCOME/LAND CONTRACTS		each additional $200		HIPAA SIGNED? Yes ☐ No ☐ PREV ☐
INTEREST/DIVIDENDS INCOME		**5.** LIABILITIES AGAINST AVAILABLE ASSETS (401K Loan)		*BC/BS covers only Physician services in our agency.*
NET PROFIT-BUSINESS/TRUST INCOME		**NET ASSETS**		Letter Ins. Info, changes, MM, pre- auth
OTHER INCOME		**7. TOTAL EXPENSES** (from expense sheet #6)		Sp. Down amt. $
TOTAL GROSS ANNUAL INCOME+		**8.TOTAL** (net annual income + net available assets – total expenses) = annual ability to pay		Letter – Medicare one-time authorization Letter - Medicare Regln's
NO OF DEPENDENTS INC/YOURSELF		**9. MONTHLY ATP (#8 ÷ 12 Mos)**		☐ **Y** ☐ **N** ref'd to DHS
$4750 exemption $2700 deaf, blind, disabled $400 Qualified Disabled Veteran				☐ **Y** ☐ **N** gave expense analysis/Adm Rules ATP form ☐ **Y** ☐ **N** gave copy of financial
TOTAL (go to schedule)				☐ **Y** ☐ **N** requested ST Income tax

I certify that the above information is correct. I agree to notify the CMHSP of any changes in this information during the course of treatment. Further, I authorize payment directly to the CMHSP for any third-party benefits to which I am entitled and authorize the release of information needed to process third-party claims. I understand that my ability to pay for mental health services has been determined to be $_____ per month, and that if I receive services, state law requires me to pay this fee. The total of my ability to pay plus insurance benefits will not exceed the total cost of the services. **NOTIFY US IMMEDIATELY OF ANY INSURANCE CHANGES. INFORM US IF PRE-AUTHORIZATION OF MENTAL HEALTH SERVICES IS REQUIRED. FAILURE OF NOTIFICATION MAY RESULT IN FULL COST OF SERVICES TO YOU.**

SIGNED _____ DATE _____

Relationship to consumer: _____

WITNESS _____ DATE _____

I AM THE BIOLOGICAL PARENT OF THIS CONSUMER

SIGNED _____ DATE _____