FINANCIAL INFORMATION SHEET

Date:___________ Renewal Date:______________ Case #:______________

Client Name:____

Employer:____ Dependents:_________

Address:____

Length of Employment:_____________________________________

	Primary Insurance	**Secondary Insurance**
Insurance Company		
Policy Holder		
Relation to Client		
Policy Holder ID #		
Policy Holder Employer		

CURRENT GROSS INCOME:
(Use yearly gross income rounded to the nearest whole dollar)

	Monthly/Weekly/Bi-weekly	**Annual**
Client's Income		
Spouse's Income		
Father/Guardian Income		
Mother/Guardian Income		
Other Income		

Specify Other:____
(Other Income ex: SSI, Unemployment, Worker's Comp, Child Support)

Public Assistance:____

____________________	______________	_______________________
Adjusted Gross Income	**Exemptions**	**Michigan Taxable Income**

The information stated above is accurate to the best of my knowledge.

____ _____________________

Signature Date

FINANCIAL INFORMATION AGREEMENT

This ability-to-pay (monthly deductible) has been determined based on the adult responsible party's most recently filed state income tax return or those financial documents that are legally available. In this case, ability-to-pay has been determined based on the same factors that calculate taxable income. If my insurance company pays 100% of the charges, I will not be charged my ability-to-pay. If my insurance company has limited or partial coverage, I am responsible for my balance, not to exceed my monthly ability-to-pay unless the responsible party willfully fails to provide relevant insurance coverage information to the department or the community mental health services program, or if a responsible party willfully fails to apply to have insurance benefits that cover the cost of services provided to the individual paid to the department or community mental health services program, the responsible party's ability to pay shall be determined to include the amount of insurance benefits that would be available. If the amount of insurance benefits is not known in a case described in this section, the responsible party's ability to pay shall be determined to be the full cost of services.

I UNDERSTAND I HAVE 30 DAYS TO APPEAL MY ABILITY-TO-PAY. This requires total financial disclosure of all income, expenses, assets, and liabilities. I understand that willful failure to provide required information will result in my being liable for full charges. Information required includes: insurance card, proof of income, number of dependents, and/or any other necessary documentation. I authorize Ionia County Community Mental Health to release information in my records to obtain payment for services from my insurance company.

"This department and the community mental health services programs shall make a reasonable, bona fide collection effort and shall adopt policies that shall be consistently applied to all responsible parties for collection of determined ability-to-pay amounts. The amounts collected shall not be more than the determined ability-to-pay, plus any cost awarded by the court." (Mental Health Code Rule 8526).

Monthly Ability to Pay: $__________________

SIGNATURE:____ **DATE:_______________**

Driver's License Number: ________________________

WITNESS:____ **DATE:_______________**