Grace Health

Sliding Fee Discount Application

Patient Name _____ Date of Birth _____

Address _____

(street) (city) (zip code)

Home Telephone Number _____

Do you receive income? ❑ Yes ❑ No

Please list all persons living at the above address (*additional names may be listed on other side*)

Full Name	Relationship to Patient	Date of Birth	Patient of Grace Health *(please ✓one)*		Income *(please ✓one)*	
			Yes	No	Yes	No

Number of people in household _____ (*may be different than number of family members*)

Health Insurance: ❑ Blue Cross ❑ Medicare ❑ Medicaid ❑ Other ❑ None

Do you have dental insurance and/or vision insurance? ❑ Yes ❑ No

Name of insurance(s): _____

The above information is correct to the best of my knowledge. I understand that it is my responsibility to pay the fee established according to my household income and family size. I agree to notify Grace Health within 30 days of any change in my income. I understand that if I provide false information or withhold financial income, I will be disqualified from the discount program.

Signature _____ Date _____

_____ **I hereby give my permission for Grace Health to release this application along with my financial information to Bronson Battle Creek, Battle Creek, Michigan.**
(initial)

Please Read

This discount program is made available by a grant from the US Department of Health and Human Services. The schedule of discounts is available for review upon request. Applications will be reviewed by Grace Health annually.

For Office Use Only

Documents to be Returned:

Application Completed	Date	Initials	Proof of Income	Date	Initials
UDS Completed			❑ requested		
Adjustment Applied			❑ received		
Eligibility determined at Category: ❑ A ❑ B ❑ C ❑ D					
Start Date:			Expiration Date:		

Annual Income $ _____ **or** Monthly Income $ _____

A completed application must include your proof of income. Application and income information can be emailed to PatientFinancialServices@gracehealthmi.org. Please call 269-441-3456 if you need assistance.