Admission Date:	Agency ID (optional):

## MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE (MCOSA) VERIFICATION OF INCOME & FEE AGREEMENT FORM

Name:							_
Name:(Last)			(First)			(Middle)	
Social Security Number	r (required):		Date	of Birth	n:		-
Marital Status: □ Singl	e	with part	tner □ Divo	rced	□ Separated	□ Widowed	
Current County of Res	idence:   Macomb	□ Othe	r				-
Number of Dependents	s (include self):		Ages (includ	le self):	:		_
I understand that a peby eligibility guidelin							equired
Hourly Wage: \$	Hours	worked	in past two (2)	weeks	s:		_
Annual Personal Incon	ne: <u>\$</u>	_	Annual House	hold In	icome: \$		-
	□ Employment □ Alimony/Child Supp □ Spouse/partner	oort	□ Disability			y if you are unde cify):	-
I understand that pu health insurance stat				last re	esort, and I c	ertify that my	<u>current</u>
Private/Employer Hea	alth Insurance:					er:	
Medicaid: Medicaid w/Deductib	le/Spend-Down:	☐ Yes	⊔ No □ No	Pian r Deduc	name: ctible Amount (i	if known): \$	
Healthy Michigan Pla	-						
Medicare:		□ Yes					
VA Healthcare Benefi	ts:	□ Yes	□ No				
Client to read and initia	al:						
I verify that the required to provide for public funds and/		e above	information f	or the	purpose of su	ıbstantiating el	
I understand employer, etc.), inclu my insurance, MCOS		lealthy	Michigan Pla	n, and	do not apply		
I understand Michigan, Block Gra enrolled in any subs treatment program, I responsible for any o	tance use treatmen ICOSA will <u>not</u> fund	ram at it elsew	the same tir here. If I cho	ne, an ose to	d will inform remain at my	my therapist other substar	if I am nce use

## **COMPLETED BY PROVIDER:**

## <u>Section 1 – Verification of Residency</u> – Maintain proof of documentation in client file

	Q O	Driver's License/State ID with Macomb County Address  Mail addressed to client with Macomb County Address
	Q	Other
		<u>- Admission Category</u> – Meets MCOSA Quality Assurance Guidelines, ASAM Criteria and Medical criteria for admission to the following category below:
10000	Oity	chang for damission to the following category below.
	Q	Detox/Residential – no copay
	Q	Medication Assisted Treatment
	Q	IOP/Outpatient
	Q	Outpatient Significant Other Admission ( <i>Maximum length of outpatient funding up to 12 sessions in 90 days; not eligible for reauthorization</i> )
	Q	Outpatient Relapse Prevention (Admission for an individual with a diagnosis of Substance Use
	V	Disorder in Sustained Full or Partial Remission, with the sole purpose of averting an impending relapse. Maximum length of outpatient funding up to 90 days. If diagnosis changes to active SUD
		during treatment, update admission category)
		Case Management – no copay
		Peer Recovery Coach – no copay Adolescent Outreach Program – no copay
	Q	Adolescent Odtreach Program – no copay
Section	on 3	- Reimbursement Level Assignment
Tyne c	of In	come Verification (*attach proof to this Fee Agreement form):
. , po c	0	Medicaid/Healthy Michigan (verified in the MCOSA data system)
	Q	*Pay stub
	Q	*Income tax return
	Q	*Unemployment
	Q	*Receipt of application for Healthy Michigan Plan/Medicaid
	Q	*Other:
Ch	eck	one:
Q	Me	edicaid: No co-payment
Q		ealthy Michigan Plan: No co-payment \$ Effective Date:
Q		ommunity Grant: Co-payment amount per service:
Explai	nati	on for exception, if applicable:

**Note:** There is a minimum fee for **Community Grant (Block Grant/PA2)** clients. Those needing to have this fee waived must complete the "MCOSA Client Fee Waiver Request/Authorization" form, which must be forwarded to MCOSA for approval. See QA Guidelines in Chapter 3 of the MCOSA Provider Manual for instructions.

Signature:

Date:

**Agency Authorization** 

Date:

Signature:

**Client Acknowledgment & Acceptance of Fee** 

Fee Review  eview of assigned fees is required every 90 days, when submitting re-authorization nt's financial situation changes, whichever comes first.  Fees Reviewed on (Date):  Financial Situation Changed:	ment)
res financial situation changes, whichever comes first.  Fees Reviewed on (Date):  Financial Situation Changed: □ No (skip to signatures) □ Yes  If yes, current household income \$ (attach verification to fee agreed Revised Fees Amount: \$ New Amount Effective On (Date	ment)
Financial Situation Changed: □ No (skip to signatures) □ Yes  If yes, current household income \$ (attach verification to fee agreed New Amount Effective On (Date	ment) e):
If yes, current household income \$ (attach verification to fee agreed Revised Fees Amount: \$ New Amount Effective On (Date	ment) e):
Revised Fees Amount: \$ New Amount Effective On (Date	ment) e):
xplanation for exception, if applicable:	
ient Acknowledgment & Acceptance of Fees: Agency Review:	
gnature: Date: Signature:	Date:
Fees Reviewed on (Date):	
Financial Situation Changed: □ No (skip to signatures) □ Yes	
If yes, current household income \$ (attach verification to fee agree	ment)
Revised Fees Amount: \$ New Amount Effective On (Date	
xplanation for exception, if applicable:	
lient Acknowledgment & Acceptance of Fees: Agency Review:	

Client Acknowledgment & Acceptance of Fees:

Signature: Date: Signature: Date:

(Attach additional pages of "Fee Reviews" to this fee agreement packet, if needed.)

**Explanation for exception, if applicable:** 

Fees Reviewed on (Date):

Financial Situation Changed: ☐ No (skip to signatures) ☐ Yes