Admission Date: _____ Agency ID (optional): _____

MACOMB COUNTY COMMUNITY MENTAL HEALTH SUBSTANCE USE DISORDER (MCCMH-SUD)
VERIFICATION OF INCOME & FEE AGREEMENT FORM

Name: _____
(Last) (First) (Middle)

Social Security Number (required): _____ Date of Birth: _____

Marital Status: □ Single □ Married/living with partner □ Divorced □ Separated □ Widowed

Current County of Residence: □ Macomb □ Other _____

Number of Dependents (include self): _____ Ages (include self): _____

I understand that a portion of the cost of my treatment may be subsidized by public funds. As required by eligibility guidelines, I hereby certify that my *current* yearly income is as follows:

Hourly Wage: $_____ Hours worked in past two (2) weeks: _____

Annual Personal Income: $_____ Annual Household Income: $_____

Source(s) of Income:	□ Employment	□ Unemployment	□ Parent (only if you are under 18)
Documentation	□ Alimony/Child Support	□ Disability	□ No Income (Attestation Letter)
Required	□ Spouse/partner	□ Public Assistance	

I understand that public funding should be the funding of last resort, and I certify that my *current* health insurance status is as follows (check all that apply):

Private/Employer Health Insurance:	□ Yes	□ No	If yes, Name of Insurer: _____
Medicaid:	□ Yes	□ No	Plan Name: _____
Medicaid w/Deductible/Spend-Down:	□ Yes	□ No	Deductible Amount (if known): $_____
Healthy Michigan Plan (HMP):	□ Yes	□ No	Plan Name: _____
Medicare:	□ Yes	□ No	
VA Healthcare Benefits:	□ Yes	□ No	

Client to read and initial:

_____ ***I verify that the above statements are true, to the best of my knowledge. I understand that I will be required to provide verification of the above information for the purpose of substantiating eligibility for public funds and/or determining the fees to be charged for the services provided.***

_____ ***I understand that if I am otherwise eligible for third-party insurance coverage (private, employer, etc.), including Medicaid or Healthy Michigan Plan, and do not apply for, or decline to use my insurance, MCCMH-SUD is not obligated to supplement the cost of my treatment.***

_____ ***I understand that I cannot be enrolled in more than one MCCMH-SUD-funded (Medicaid, Healthy Michigan, Block Grant) treatment program at the same time, and will inform my therapist if I am enrolled in any substance use treatment elsewhere. If I choose to remain at my other substance use treatment program, MCCMH-SUD will not fund my current request for substance use treatment and I will be responsible for any costs incurred.***

COMPLETED BY PROVIDER:

Section 1 – Verification of Residency – *Maintain proof of documentation in client file*

- Driver's License/State ID with Macomb County Address
- Mail addressed to client with Macomb County Address
- Other _____

Section 2 – Admission Category – Meets MCCMH-SUD Quality Assurance Guidelines, ASAM Criteria and Medical Necessity criteria for admission to the following category below:

- Detox/Residential – no copay
- Medication Assisted Treatment
- IOP/Outpatient
- Outpatient Significant Other Admission (*Maximum length of outpatient funding up to 12 sessions in 90 days; not eligible for reauthorization)*
- Outpatient Relapse Prevention (*Admission for an individual with a diagnosis of substance use 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

Section 3 – Reimbursement Level Assignment

Type of Income Verification (**attach proof to this Fee Agreement form)*:

- Medicaid/Healthy Michigan (verified in the MCCMH-SUD data system)
- *Pay stub
- *Income tax return
- *Unemployment
- *Receipt of application for Healthy Michigan Plan/Medicaid
- *Lack of Income Attestation Letter from Person Served/Support Person

Check one: o Medicaid: No co-payment o Healthy Michigan Plan: No co-payment $_____ Effective Date: _____ o Community Grant: Co-payment amount per service:
Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fee		**Agency Authorization**	
Signature:	Date:	Signature:	Date:

Client Name: ________________________________ *Agency ID (optional):* ___________________

Fee Review

A review of assigned fees is required every 90 days, when submitting re-authorization request, or when client's 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 agreement)
Revised Fees Amount: $_______________________ New Amount Effective On (Date): ______________

Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fees:	**Agency Review:**
Signature: Date:	Signature: Date:

Fees Reviewed on (Date): ______________

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

If yes, current household income $______________ (attach verification to fee agreement)
Revised Fees Amount: $_______________________ New Amount Effective On (Date): ______________

Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fees:	**Agency Review:**
Signature: Date:	Signature: Date:

Fees Reviewed on (Date): ______________

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

If yes, current household income $______________ (attach verification to fee agreement)
Revised Fees Amount: $_______________________ New Amount Effective On (Date): ______________

Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fees:	**Agency Review:**
Signature: Date:	Signature: Date:

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