Macomb County Community Mental Health
FEE DETERMINATION AGREEMENT / INSURANCE AUTHORIZATION

In accordance with the Michigan Department of Community Mental Health (MDCH) guidelines, all MCCMH consumers, except full Medicaid eligible consumers, are assessed a monthly service fee, based on MDCH sliding fee scales, or full financial review regardless of insurance, Medicaid or Medicare coverage.

The provider must be notified of any financial or insurance changes. During the course of treatment a redetermination of the fee may be requested by the Responsible Party.

When the Responsible Party willfully fails to provide information necessary to apply for or secure insurance that covers, in part or in whole, the cost of services provided, the ability to pay of the Responsible Party shall be determined to be the full cost of services.

- ✓ Consumer has active Medicaid? Yes _____ No _____
- ✓ Consumer has MIChild? Yes _____ No _____
- ✓ _____ Due to Medicaid or MIChild eligibility no ability to pay was assessed. A financial review will be completed should Medicaid eligibility lapse.
- ✓ Consumer's age (please check): minor (under 18) _____ adult (18 and over) _____
- ✓ Responsible Party's **Monthly Taxable** Income: _____ or **Yearly Taxable** Income: _____
- ✓ Income Documentation (please check below):
  MI Tax Return _____ Fed. Tax Return _____ W-2's _____ Pay Stub _____ Other _____
- ✓ Copy Attached? _____ Visually Verified? _____ Full Financial for minor attached? _____
- ✓ Monthly Fee based on Ability to Pay Schedule: _____ $_____per month
- ✓ Full Financial Requested? _____ Full Financial must be completed by: _____
  (30 days from signature date)
- ✓ Contact Name and Phone Number: _____
- ✓ Monthly Fee based on Full Financial Review of Income $ _____per month
- ✓ Document monthly non-taxable benefits, if any (SS, SSI, SSDI, etc.): _____
- ✓ Medicaid Deductible / Spend-down? Yes _____ No _____
- ✓ Application for Medicaid needed? Yes _____ No _____ If Yes, by what date: _____
  (45 days from signature date)

INSURANCE INFORMATION

Consumer's Name: _____ Case Number: _____

PRIMARY INSURANCE

Insurance Name: _____

Contract ID #: _____

Insurance Group #: _____ Insurance Phone #: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relation to Consumer: _____

Subscriber's Address: _____
Street Number and Name

_____
City, State, and Zip Code

OTHER INSURANCE

Is there any other insurance? _____ (yes or no)

IF THERE IS OTHER INSURANCE, PLEASE LIST BELOW:

Insurance Name: _____

Contract ID #: _____

Insurance Group #: _____ Insurance Phone #: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relation to Consumer: _____

Subscriber's Address: _____
Street Number and Name

_____
City, State, and Zip Code

Consumer Insurance Authorization

I authorize Macomb County Community Mental Health (MCCMH) to release to the above Health Insurance Company(s) or its intermediaries or carriers, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance either to myself or to MCCMH.

My signature documents that the FEE AGREEMENT / INSURANCE AUTHORIZATION has been explained to me, and that I agree with the above statements and information. My signature also documents that the fees to be charged for services and the process for communication with my health insurer(s) have been explained to my satisfaction.

Responsible Party's Signature Below:

_____ _____
Consumer's Signature / Date (if applicable) Witness Signature / Date (if applicable)

_____ _____
Guardian's Signature / Date (if applicable) Witness Signature / Date (if applicable)

_____ _____
Parent's Signature / Date (if applicable) Account Clerk's Signature / Date

_____
Signature of Preparer / Date