MUNISING MEMORIAL
HOSPITAL & HEALTH SERVICES

UNINSURED DISCOUNT APPLICATION

Michigan Medicaid Expansion mandates that we accept as payment in full 115% of our Medicare rate from UNINSURED patients whose household income is less than 250% of the Federal Poverty Guidelines. You may be eligible for this discount if your household income falls into the ranges shown on the back of this application. To receive the current payment discount, you must complete this brief application form.

PATIENT INFORMATION

Name: _____ Visit ID No.: _____

Physical Address: _____
(Street) (City) (State) (ZIP)

Mailing Address: _____
(Street or P.O. Box) (City) (State) (ZIP)

Social Security No.: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient:
Employment Status: □Self □Retired □Disabled □Unemployed □Student □Dependent

Employer: _____Occupation: _____ Employed Since: _____

Employer's Address _____ Phone: _____

Total Monthly Income $_____

Spouse:
Employment Status: □Self □Retired □Disabled □Unemployed □Student □Dependent

Employer: _____Occupation: _____ Employed Since: _____

Employer's Address _____ Phone: _____

Total Monthly Income $_____

Other Household Income $_____/Month Source: □Alimony □Child Support □Other _____

DEPENDENT INFORMATION (List all people living in the household and their relationship to applicant.):

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Michigan Medicaid Expansion Mandated Uninsured Payment Discount 40%*

Family Size	Above	Below	Above	Below
1	$0	$16,040	$16,041	$30,150
2	$0	$21,546	$21,547	$40,500
3	$0	$27,052	$27,053	$50,850
4	$0	$32,558	$32,559	$61,200
5	$0	$38,065	$38,066	$71,550
6	$0	$43,571	$43,572	$81,900
7	$0	$49,090	$49,091	$92,275
8	$0	$54,623	$54,624	$102,675
9	$0	$60,169	$60,170	$113,100
10	$0	$65,729	$65,730	$123,550
% of Poverty	133%		250%	
	Apply for Medicaid		**Eligible for Discount**	

Applies to HOSPITAL charges beginning 1/1/17 only.

Michigan Medicaid Expansion mandates that we accept as payment in full 115% of our Medicare rate from UNINSURED patients whose household income is less than 250% of the Federal Poverty Guidelines. To receive the current payment discount of 40% you must complete an application form.

** Discount shown applies to outpatient services; inpatient discount will be calculated as needed.*

The following information must be provided with the completed application for income to be determined:

- **Pay stubs for the past 3 months (supporting <u>all</u> household income)**
- **Copy of most recently filed federal income tax return**
- **Copy of W-2(s) or documentation of any other income (unemployment, pension)**

I hereby certify that the above information is true and correct. I authorize Munising Memorial Hospital to contact the employers and institutions listed on this application to verify its accuracy, if deemed necessary. I further authorize the employers/institutions to release such information to Munising Memorial Hospital.

Patient Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Please return completed application to:

Munising Memorial Hosptial
Attn: Billing Dept.
1500 Sand Point Road
Munising, MI 49862