Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

Sliding Fee Discount Plan

Thunder Bay Community Health Service provides services to patients regardless of their ability to pay. For qualification, patients must provide a completed application and proof of income. Proof of income examples include, but are not limited to, recent pay stubs, Social Security Income (Medicare Award Letter), Federal or Michigan 1040 Forms, W-2 Forms, Proof of Pension, Unemployment Determination, or a letter from a friend or family member that is providing support if there is no income to show. Upon approval, the discount will be honored for one year from the date of application. Patients must reapply annually. Discounts are offered based on family size and income and could result in a minimum amount due of $10.00 for medical or behavioral health services, $30.00 for dental services, $45.00 for optical lenses and frames, and $3.00 per prescription plus the cost of the medication. Assistance for insurance enrollment will be provided for eligible patients. The minimum payment is expected at the time of service.

Services Covered and Excluded

Professional Services: Discounts apply to all in office professional services. Services not eligible for discount include select medical supplies, upgrades to optical lenses and frames and a portion of the pharmacy medication. The minimum fee may not apply to all dental services.

Referred Care: Discounts do not apply to out of office referred care such as referrals to specialists, emergency room, and testing such as x-rays, CT scans, MRIs and pathology.

Lab: Discounts apply to in office charges for laboratory services. Lab tests referred to Quest Labs qualify for discount.

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Discount Plan Application

Patient/Applicant Name:_____Date of Birth:_____

Address:

_____

(City) (State) (Zip)

Telephone:_____Employer:_____

Self / Spouse / Dependents Under Age 18	Relationship	Date of Birth	All Earnings Weekly Monthly or Annual

Proof of income is required for earnings listed

Do you have medical insurance? (Please list)_____

Do you have dental insurance? (Please list) _____

We assist the uninsured and underinsured obtain health insurance. Would you like us to contact you about this? Yes ☐ No ☐

I certify that the information listed above is true and accurate and that I have no other income not listed. I understand that the information listed is subject to review by federal and/or state enforcement agencies or others as required.

_____

Signature Date

For Office Use Only

Approved Discount Rate_____ Effective Date_____ Recertification Date_____

Revised 10/2023