



CLEARLY PRINT LAST NAME

- Original (Initial)
- Annual Update/Income Change
- Proof of Income Verification Fee

Ability to Pay/Fee Determination

Consumer Name: _____ Responsible Person: _____

Consumer Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Home Phone: _____ Home Phone: _____

Other Phone: _____ Resp. Party Soc. Sec. #: _____

D.O.B: _____ Soc. Sec. #: _____ Case #: _____

Number of Dependents: _____ Total Annual Household Income: \$ _____

Principle Source of Income:

SDA SSI SSDI Employment Wages Retirement Income Alimony/Child Support

No Income Source Other Public Assistance/Other, Not Listed: _____

Taxable Income Information:

State Taxable Income (Line 16) from most recent MI-1040 Tax Return; Tax Year (_____) \$ _____

-- OR --

Taxable Income Estimate - From Income Estimate Worksheet \$ _____

Ability to Pay Determination:

Annual Ability to Pay - From Ability to Pay Schedule \$ _____

The method of calculation was explained to me and I understand my ability to pay for mental health services, has been determined to be \$ _____ **maximum annually**. I will remit a minimum of at least \$ _____ **a month** until either the annual maximum is paid in full or the full cost of services is reached, whichever is less. I further understand that if I do not pay or if I do not submit to LifeWays any insurance checks covering LifeWays services that are paid directly to me, my balance may be submitted to a collection agency. I also understand LifeWays may be confirming my income with the Michigan Department of Treasury if I did not provided my Michigan State Income Tax information for the assessing of this ability to pay. **I understand that I am financially responsible for all changes and/or co-pays that will not exceed my assessed maximum ability to pay.**

Any falsification of this document will result in being charged full cost of service.

You have the right to appeal the ability to pay determination within thirty (30) calendar days of the determination date. If you wish to do so, contact Customer Services at (517) 780-3332 or 1-866-630-3690.

Signed: _____ Date: _____
(Consumer/Parent/Guardian)

Signed: _____ Date: _____
(Information Coordinator and Agency Name)

All payments for ability to pay LifeWays should be made to: 1200 North West Avenue Jackson, MI 49202

Note: Financial Liability for Consumers with Medicaid: An ability to pay determination of zero does require that if anytime during the year that the individual's Medicaid status changes, a new ability to pay will be completed and the new financial information will be requested.

WORK DISCLAIMER

I Agree to the Following	<p>My signature below certifies that, at this time, I am unemployed and have no source of income that provides me with funds to pay for the Mental Health Services I am requesting.</p> <p>Furthermore:</p> <p><input type="checkbox"/> I will apply for Medicaid at this time and I have been provided the information, assistance, and paperwork to complete this application.</p> <p><input type="checkbox"/> I am not willing apply for Medicaid at this time and I understand that I will be charged full fee.</p> <p>EMPLOYMENT NOTICE: If during the course of receiving Mental Health Services I am able to obtain employment or other income, I will notify my primary clinician and complete the required paperwork for a new fee assessment.</p>
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Signatures	Consumer Name: (Print)	Consumer ID:
	Consumer Signature:	Date:
	Signature:	Date:

**LifeWays
Public Mental Health System
Ability to Pay Schedule**

<u>State Taxable Income</u>		<u>Ability to Pay</u>	
<u>From</u>	<u>To</u>	<u>Monthly</u>	<u>Annually</u>
\$ 10,001.00	\$ 11,000.00	\$ 11.00	\$ 132.00
\$ 11,001.00	\$ 12,000.00	\$ 14.00	\$ 168.00
\$ 12,001.00	\$ 13,000.00	\$ 18.00	\$ 216.00
\$ 13,001.00	\$ 14,000.00	\$ 22.00	\$ 264.00
\$ 14,001.00	\$ 15,000.00	\$ 27.00	\$ 324.00
\$ 15,001.00	\$ 16,000.00	\$ 32.00	\$ 384.00
\$ 16,001.00	\$ 17,000.00	\$ 38.00	\$ 456.00
\$ 17,001.00	\$ 18,000.00	\$ 45.00	\$ 540.00
\$ 18,001.00	\$ 19,000.00	\$ 53.00	\$ 636.00
\$ 19,001.00	\$ 20,000.00	\$ 62.00	\$ 744.00
\$ 20,001.00	\$ 21,000.00	\$ 72.00	\$ 864.00
\$ 21,001.00	\$ 22,000.00	\$ 83.00	\$ 996.00
\$ 22,001.00	\$ 23,000.00	\$ 95.00	\$ 1,140.00
\$ 23,001.00	\$ 24,000.00	\$ 108.00	\$ 1,296.00
\$ 24,001.00	\$ 25,000.00	\$ 122.00	\$ 1,464.00
\$ 25,001.00	\$ 26,000.00	\$ 137.00	\$ 1,644.00
\$ 26,001.00	\$ 27,000.00	\$ 153.00	\$ 1,836.00
\$ 27,001.00	\$ 28,000.00	\$ 170.00	\$ 2,040.00
\$ 28,001.00	\$ 29,000.00	\$ 188.00	\$ 2,256.00
\$ 29,001.00	\$ 30,000.00	\$ 206.00	\$ 2,472.00
\$ 30,001.00	\$ 31,000.00	\$ 225.00	\$ 2,700.00
\$ 31,001.00	\$ 32,000.00	\$ 244.00	\$ 2,928.00
\$ 32,001.00	\$ 33,000.00	\$ 264.00	\$ 3,168.00
\$ 33,001.00	\$ 34,000.00	\$ 284.00	\$ 3,408.00
\$ 34,001.00	\$ 35,000.00	\$ 304.00	\$ 3,648.00
\$ 35,001.00	\$ 36,000.00	\$ 324.00	\$ 3,888.00
\$ 36,001.00	\$ 37,000.00	\$ 344.00	\$ 4,128.00
\$ 37,001.00	\$ 38,000.00	\$ 364.00	\$ 4,368.00
\$ 38,001.00	\$ 39,000.00	\$ 384.00	\$ 4,608.00
\$ 39,001.00	\$ 40,000.00	\$ 405.00	\$ 4,860.00
\$ 40,001.00	\$ 41,000.00	\$ 426.00	\$ 5,112.00
\$ 41,001.00	\$ 42,000.00	\$ 447.00	\$ 5,364.00
\$ 42,001.00	\$ 43,000.00	\$ 468.00	\$ 5,616.00
\$ 43,001.00	\$ 44,000.00	\$ 489.00	\$ 5,868.00
\$ 44,001.00	\$ 45,000.00	\$ 510.00	\$ 6,120.00
\$ 45,001.00	\$ 46,000.00	\$ 531.00	\$ 6,372.00
\$ 46,001.00	\$ 47,000.00	\$ 552.00	\$ 6,624.00
\$ 47,001.00	\$ 48,000.00	\$ 573.00	\$ 6,876.00
\$ 48,001.00	\$ 49,000.00	\$ 594.00	\$ 7,128.00
\$ 49,001.00	\$ 50,000.00	\$ 615.00	\$ 7,380.00

For State Taxable Income over \$50,000.00, ability to pay shall be %15 of that income.

CONSUMER NAME _____

CASE NUMBER _____

INCOME ESTIMATE

Instructions: (See below)

- Line 1: Enter the year for which all the income and expenses relate to.
- Line 2: Enter the number of dependents in the household.
- Line 3: Using the most current Form W-2, enter the wages earned. If multiple forms, add them and then enter the total.
- Line 4: Using Form 1099-INT, enter the total amount of interest earned from Savings, Bonds, Certificates of Deposit, etc.
- Line 5: Using Form 1099-DIV, enter the total amount of dividends earned from Stocks, Mutual Fund, etc.
- Line 6: Enter income earned from self-employment less expenses related to that income.
- Line 7: If any assets were sold during the year, enter the gain or loss incurred.
- Line 8: Enter income earned from rental properties, less expenses related to that rental property.
- Line 9: Enter alimony received as a positive number and alimony paid as negative. Do not include child support payments.
- Line 10: Add lines 3 through line 9. This is the Income you use to calculate the ATP
- Line 11: Multiply the number of dependents by **\$3,600**. *[Revised 1/21/10; Changes Jan. 1st of every year.]*
- Line 12: Subtract line 11 from line 10.

Calculation For Income Estimate

- 1 Year in which income was earned. _____
- 2 Number of dependents. _____

Income (Enter zero if none for each line.)

- 3 Wages and salaries (Form W-2) _____
- 4 Interest income (Savings, Bonds, Certificates, etc.) _____
- 5 Dividend income (Stocks, Mutual Funds, etc.) _____
- 6 Net income from self-employment _____
- 7 Gain (loss) from sale of assets _____
- 9 Alimony _____

- 10 Total _____

- 11 Less number of dependents – Times **\$3,600**.
[Revised 1/21/10. This amount will change January 1st of each year and is based on amount allowed on Federal Tax 1040 Form.] _____

- 12 Taxable Income Estimate _____



WILLFUL FAILURE TO PROVIDE RELEVANT FINANCIAL INFORMATION

I understand that by willfully refusing to provide the relevant financial information needed to determine my Ability to Pay, I agree to pay the full cost of services less any amount reimbursed by my insurance.

Consumer Name

Case Number

Consumer/Guardian Signature

Date

- Check here to confirm Consumer has been advised s/he cannot be provided services if s/he fails to provide or disclose financial information or refuses to sign this form.

Information Coordinator

Date