TAYLOR STREET PRIMARY CARE CLINIC

1550 Taylor Street, Detroit, MI 48206
(P) 313-486-5501 | (F) 313-486-9337
TaylorStreetClinic.com

SLIDING FEE ELIGIBILITY FORM

It is the policy of Taylor Street Primary Care Clinic (TSPCC) to provide essential medical services regardless of the patient's ability to pay. Discounts are offered based upon household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for one year, after which the patient must reapply.

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by TSPCC before a discount will be granted. If the applicant appears to be ineligible for Medicaid, a written denial of coverage by Medicaid may also be required.

Medical	The discount is applied to all in-office services and off-site services provided by your healthcare providers.
Pharmacy	Samples are provided, when available, without charge. Outside pharmaceutical benefits are excluded.
Lab & X-ray	The discount is applied only to in-office laboratory services. Outside laboratory services and consulting radiology interpretations are excluded.

Please fill out the following information to determine if you qualify for a discount on medical expenses at the Taylor Street Primary Care Clinic. This information will be kept confidential. In addition to this form, you will need to bring a **complete copy of your latest, filed and signed, tax return along with the w-2 for the most recent tax year.** If you do not file your taxes independently, you must provide one of the following from the most recent year:

- ☐ A complete copy of your W2's or 1099's,
- ☐ A complete tax return from your parent or guardian for the most recent tax year
- ☐ An award letter from the Social Security Administration or benefit letter from your local DHS Office

Your annual income will be used to calculate your rate of discount. **Each office visit will include a minimum payment before the discounted prices are effective.**

FIRST NAME:	**LAST NAME:**		
STREET ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**
PHONE (Cell):	**PHONE (Home):**		
WHAT IS YOUR MARITAL STATUS? □ Single □ Married □ Separated □ Divorced □ Widow(er) □ Other: ___			
HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD? □ One □ Two □ Three □ Four □ Five □ Six or more, please specify: __			
YOUR ANNUAL PERSONAL INCOME:	**YOUR ANNUAL HOUSEHOLD INCOME:**		
DO YOU RECEIVE ANY INCOME FROM OUTSIDE SOURCES? □ No □ Yes, please explain:			
DO YOU HAVE ANY TYPE OF INSURANCE THAT MAY COVER ALL OR A PORTION OF YOUR MEDICAL EXPENSES? □ No □ Yes, please explain:			

I declare the above information is true and I have given the Taylor Street Primary Care Clinic permission to investigate any information provided on this application. I understand that this information will be kept in confidence. I also understand that if my income should change. I am responsible for notifying TSPCC on my next visit to the clinic of any changes.

Signature: _____ Date: _____

For Clinic Use Only: Sliding fee rate: _____ Signed: _____ Date: _____

Revised 03/2020