

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Case #: \_\_\_\_\_

*It is a requirement of the Michigan Mental Health Code that St. Clair County Community Mental Health Authority assess an ability to pay for all consumers at least annually. Since you are currently covered by Medicaid or Healthy Michigan Plan your ability to pay for CMH services is zero, however we are still required by the Michigan Department of Community Health to obtain certain financial information.*

Total Annual Household Income: \$ \_\_\_\_\_ OR Total Monthly Income: \$ \_\_\_\_\_

Source of Income: \_\_\_\_\_ (i.e., – Social Security, SSI, earned income, unemployment, etc.)

Number of Dependents \_\_\_\_\_ (including self, spouse, and dependent children)

We cannot bill your insurance company unless you provide The Authority with your insurance information. **(Please attach a copy of any new insurance card(s) front and back to this agreement).** All insurance benefits must be identified and used prior to using Medicaid benefits, as payor of last resort.

Primary Insurance:		Policy/Contract Number:	
Name of Subscriber:		Group Number/HMO:	
Insurance:		Policy/Contract Number:	
Name of Subscriber:		Group Number/HMO:	
Insurance:		Policy/Contract Number:	
Name of Subscriber:		Group Number/HMO:	
Insurance:		Policy/Contract Number:	
Name of Subscriber:		Group Number/HMO:	

If you prefer you can call and inform me of this information by phone.

Thank you for your cooperation.