CROSSPOINTE FAMILY SERVICES SLIDING FEE SCHEDULE APPLICATION INFORMATION & INSTRUCTIONS

Cash/Sliding Fee Scale Option: Crosspointe Family Services offers discounts on clinic services for patients with income at or below below 200% of the Federal Poverty Level in accordance with the enclosed established sliding fee scale.

If you are uninsured and have a low income, you may qualify for a sliding fee for your Behavioral Health needs OR if you have insurance but it does not cover behavioral health needs. This program is intended to provide care for people who otherwise may be unable to see a Behavioral Health provider.

How the Sliding Fee Scale Works:

- Applicable to all individual and families with annual incomes at or below 200 percent of the most current FPG (Federal Poverty Guidelines).
- Full discount for individuals and families with annual incomes at or below 100 percent of the federal poverty guidelines (FPG) for a nominal charge only.
- Adjustment of fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 and at or below 200 percent of the FPG.

Income means your paycheck before deductions, pension, retirement, social security income, child support, alimony, workers compensation payments, etc. from all sources for everyone residing in the household. All office visits for behavioral services are eligible for a sliding fee.

When filling in the household income and the number of people supported the following is to be taken into consideration. A household may consist of:

- Wife, Husband, and Children
- Mother, Father, and Child
- Husband and Wife
- Mother and Child
- Father and Child
- Parents or grandparents living in home
- Adult children who reside in the home
- Other relatives (in-laws, grandchildren)
- Friends/others who reside in the home
- Ex-spouses who live in the home

Any of the following items may be used as a proof of household income (include for all people living in the home):

- Payroll - One month's income (Pay stubs)

- Child Support - court order
- Alimony - court order
- SSI (Social Security Income) - letter from Social Security office
- Pensions - letter-stating allotment
- Disability - letter from Social Security office or copy of Award Letter
- Unemployment Compensation - wage transcript from State D. O. L.
- Worker's Compensation - wage transcript from State D. O. L.
- Statement from the employer
- Letter/Statement from the organization/agency providing assistance (i.e. County and or City government, Salvation Army, Church, etc.)
- Allowance/contribution - letter from Source
- Tax Return, W-2's, other documents showing means of support and annual income

Sliding Fee Schedule Application Instructions:

Please fill out the enclosed Sliding Fee Schedule Application Worksheet, provide copies of proof of income and bring to our office.

Crosspointe Family Services
Sliding Fee Application

Crosspointe Family Services policy is to provide Behavioral Health services regardless of the patient's ability to pay. Fee discounts are offered based total household income and size based on FPG. Please complete the Application Worksheet and provide copies of proof of income. (Please note we will provide services even if you do not have proof of income).

The discount will apply to all Behavioral Health services received at this clinic. This application and a new verification must be completed every 6 months. Please inquire at the business office if you have questions.

I _____am applying for Crosspointe Family Services Sliding Fee Program to access behavioral health services for myself and/or my family members or others I live with.

- I agree to provide all documents necessary to complete the application process.
- I understand that I may need disclose personal and financial information about those I live with in order to qualify for the program.
- I understand and agree that if approved for the Sliding Fee program, I will pay the nominal fee, however services will NOT be denied if I am unable to pay.
- I agree to immediately report any changes in my family size, circumstances, and or financial situation to Crosspointe Family Services.

_____ _____

Name (Print) Signature Date

_____

Agency Witness

Crosspointe Family Services, LLC dba Crosspointe Family Services
Family Assistance Plan Application Worksheet

Name of Head of Household:		Place of Employment:		
Address:	City:	State:	Zip:	Phone:
Health Insurance Plan:		Social Security Number:		

Please list spouse and all dependents under age 18

Name:		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips etc.				
Workman's compensation, private disability insurance				
Social Security, pensions, annuity, Veteran's Benefits				
Alimony, child support, military family allotments				
Income from business, self-employment, and dependents				
Rent, interest, dividends, and other income				
Total Income				

Verification Checklist: (Attach Copies)	Yes	No
Identification/address: Driver's license, birth certificate, employment ID, Social Security card or other.		
Income: Last 3 wage stubs, prior year tax return, and proof of other sources of income.		
Insurance: Insurance card(s), Insurance Policy, EAP		
Medicaid: Application made or evidence of rejection OR Income above exceeds threshold.		

I am applying for the Sliding Fee program and certify that all information is correct and that verification is required for program eligibility.

_____ _____

Name (Print) Signature/date

Fee Category Approved: _____ Effective date: _____

Approved by: _____ Expiration date _____