SLIDING SCALE APPLICATION

|  |  |  |  |
| --- | --- | --- | --- |
| Today’s Date  |  | Name  |  |
| Date of Birth  |  | Address  |  |
| City  |  | State  |  | ZIP Code  |  |
| Home Phone  |  | Cellphone  |  |  |  |
| Applying for health coverage is NOT a prerequisite for Sliding Fee Scale Discount eligibility.  |

Please list all immediate family members and persons living in your household (spouse or life partner and children that are *under the age of 21 years)* and that are dependent on family income. Please do not include guests, elderly parents or roommates.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Family Members  | Sex  | Date of Birth  | ‘X’ if no health insurance  | Has insurance? Type:  |
| 1. (Self)  |  |  |  |  |
| 2. (Spouse/Partner)  |  |  |  |  |
| 3. (Child)  |  |  |  |  |
| 4. (Child)  |  |  |  |  |
| 5. (Child)  |  |  |  |  |

What is your gross family income BEFORE deductions (please include all working adults, above age 21)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Household member receiving income  | Estimated Annual income (per person) (Monthly Income x 12)  | Sources of Income (employment, Social Security, pension/ retirement, workers comp, child support, alimony, etc.)  | Proof of Income Date Requested/ Date Verified  | AOB Staff Notes  |
| 1. (Self)  | $  |  |  |  |
| 2.  | $  |  |  |  |
| 3.  | $  |  |  |  |
| 4. | $ |  |  |  |

**I certify that the income and household composition information is true and correct to the best of my knowledge. I have read the Sliding Fee Scale Discount Application and I will abide by all Sliding Fee Scale Discount requirements.**

**Please bring your proof of income within 7 days of submitting application.**

THE ART OF BEING PLLC offers a Sliding Fee Scale Discount program for low-income and/or uninsured patients. **See the attached Sliding Fee Scale Discount Program Scale.**

**MENTAL HEALTH SERVICES
What are the Sliding Fee Scale Discounts for mental health Services? (See Attached Sliding Fee Discount Program Scale)**

**Nominal Fee:**

Level A: Patient pays 0% for office visit

Level B: Patient pays 20% for office visit

Level C: Patient pays 40% for office visit

Level D: Patient pays 60% for office visit

Level E: Patient pays 80% for office visit

Level F: Patient pays 100% for office visit

• Patients above 200% FPL are not eligible for Sliding Fee Scale Discounts.

• We request payment of the Sliding Fee Scale Discount Fee at the date of service. SLIDING FEE SCALE **DISCOUNT PROGRAM C**

*Payment plans are available and NO patient is denied services for inability to pay.*

1. To qualify for the Sliding Fee Scale Discount Program, you must bring your family’s proof of income within 7 days.

a) Proof of Income: 2-4 pay stubs, tax forms, a letter from employer, documents verifying the amount of income from other sources, ex. Unemployment, SSI, alimony, child support etc.

b) If you do not have your proof of income at your appointment, you may estimate your family’s current gross annual income but bring documentation to the health center within 7 days.

2. If your proof of income is eligible, you will receive a discount for 12 months. Patients must re-apply for the sliding fee scale program after 12 months.

3. If you fail to bring us your proof of income within the specified date below, you may be charged the cost for your next visit. No patient is denied care for inability to pay. Billing specialists are available to arrange affordable payment plans.

**I need to bring in my Proof of Income by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive my Sliding Fee Scale Discount status.**

Payment plans are available and NO patient is denied services for inability to pay.

**STAFF USE ONLY**

ART OF BEING Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ SS Start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Per your estimated monthly income of $\_\_\_\_\_\_\_\_\_and a family size of \_\_\_\_\_\_\_\_\_ of your qualify for SS level \_\_\_\_\_\_\_\_\_ (7days) Based on your monthly income of $\_\_\_\_\_\_\_\_\_\_ and a family size of \_\_\_\_\_\_\_\_\_\_\_ you qualify for SS level \_\_\_\_\_\_\_\_\_\_ (12 months) For each office visit, patient will pay: \_\_\_\_\_\_\_\_.