SANTA ROSA COUNSELING CENTER

SLIDING FEE SCHEDULE PROGRAM

INTRODUCTION

It is the policy of Santa Rosa Counseling Center to provide mental health services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. 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 the business office before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

Adolescent patients seeking confidential care are exempt from the application process, and services are provided at the nominal rate.

REQUIRED INFORMATION

The following items are required to process your application for the Sliding Fee Scale Program. Your application will not be processed without the requested information. Any information given to Santa Rosa Counseling Center will be kept confidential. If the information proves fraudulent we reserve the right to cancel your sliding fee scale status and bill you in full for all previous visits.

- A complete listing of household members, their ages, and the relationship to the patient.
- Proof of household incomes. Any incomes by any household member must be reported (employment wages, Social Security, pensions, child support, alimony, etc.). We must have a minimum of three current check stubs for every member in the household. If check stubs are not available, you must provide a current tax form or notarized statement from the employer. Also requested is the last household bank statement including, but not limited to, checking and/or savings account and a utility bill from patient or supporter.
- If you have no income, you must have proof of applying for Medicaid benefits or a copy of Food Stamp Certification and provide a notarized letter from the person(s) that supports you.

Santa Rosa Counseling Center must be notified immediately if:

- There is a change of income of any family member in the household.
- Any member of the household obtains insurance of any kind.
- There is a change of mailing address.

SANTA ROSA
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You must pay your co-pay at the time of each visit. If you are temporarily qualified for the sliding fee scale by one of our counselors and do not supply the required documentation within five business days, you will be responsible for the remaining balance on your account. If payment is not received, Santa Rosa Counseling Center reserves the right to terminate your eligibility in the sliding fee scale program and pursue further collection efforts.

PATIENT DEMOGRAPHICS

Last Name First Middle

Residence Address City State Zip Code

Date of Birth Age Social Security Number Driver License Number State

Telephone (Home) (Cell) (Work)

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced

☐ Remarried ☐ Partnered ☐ Widowed

Gender:

☐ Male ☐ Female

CERTIFICATION OF LOW INCOME STATUS

Please list all household family members. This does not include guests, roommates, or non-dependent family members.

Source	Amount	Weekly	Bi-weekly	Monthly	Annually
Salaries and Wages (self)					
Salaries and Wages (spouse)					
Pension Plan/IRA					
Workman's Comp (SSI)					
Social Security (self/spouse)					
Social Security (children)					
SSI (supplemental security)					
Child support/Alimony					
Tip Income					
Military/VA Benefits					
Public Assistance/Food Stamps					
Stocks/CD's/Savings					

Santa Rosa Counseling Center reserves the right to inspect your tax return and/or wage statement for previous periods upon request. Eligibility will be updated on an annual basis. If there are any changes in your income status prior to your annual update, you should notify Santa Rosa Counseling Center immediately.

Please list all dependent family members by name, date of birth, and social security number. Please include yourself.

Name	Birth date	Social security number

ATTESTATION

I hereby certify that the income and family composition information supplied in the above tables is true and correct to the best of my knowledge. I understand that this document will be maintained in my permanent medical record; falsification of information may constitute a federal offense. I have read the above rules and agreed to follow them. I also understand that if I do not comply with the rules set forth, my participation in the program will be terminated. I understand that I am responsible for any past due balances owed to Santa Rosa Counseling Center prior to sliding fee scale transition.

Patient Name Patient Signature Date

Office Personnel Name Office Personnel Signature Date

OFFICE USE ONLY

Patient classification:

_______ Approved for patient responsibility ___________ %

_______ Personnel initials