Sliding Fee Schedule Program

INTRODUCTION Date Completed: _____

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. Authorized adolescent patients seeking short-term confidential care are exempt from the application process. Services are provided at the nominal rate as indicated below.

PATIENT DEMOGRAPHICS

Last Name	First	Middle	Date of Birth	Age
Street Address	City	State	Zip Code	
Phone Number (Cell)	Home	Email	Social Security Number	

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 two 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.
- 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.

You must pay your co-pay at the time of each visit. If you are temporarily qualified for the sliding fee scale and do not supply the required documentation within two weeks of the date of your application, 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.

CERTIFICATION OF INCOME STATUS

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

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

Santa Rosa Counseling Center reserves the right to inspect your tax documents and/or wage statements 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 yourself and all dependent family members by name, date of birth, and social security number.

Name	Birth date	Social security number

ATTESTATION

I attest that I have read this document completely, fully understand it, and agree to all described herein. The income and family composition information supplied in the above tables is true and correct to the best of my knowledge. I understand that I may be terminated from the program if I do not remain in compliance with the requirements described herein and/or if I have provided false information. I understand that I am responsible for any past due balances owed to Santa Rosa Counseling Center prior to sliding fee scale program eligibility.

Patient Name	Patient Signature	Date

If you are signing this document as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

Name	Relationship	Signature	Date

OFFICE USE ONLY

The nominal fee (maximum amount charged to a qualifying patient who is at 100% of poverty) is $0.00.

_____ Eligible Patient responsibility percentage: _____

_____ Ineligible Reason: _____

Office Personnel Name	Office Personnel Signature	Date