Horizon Recovery
Sliding Fee Application

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed, signed & dated, and submitted to the receptionist, along with proof of income (see listing on back side for acceptable forms of income)

Head of Household: Last_____First_____ Phone_____

Mailing Address:_____City_____State_____Zip_____

Have you or any ofyour household members applied for Medicaid (Title XIX)? Yes Z] No ☐

SOURCES OF INCOME: All members living in the household. "Household" is considered all persons living with you at the same address. If living situation is temporary, please advise Amazing Grace Center staff of your situation.

Source	Amount (S)	Weekly	Bi-Weekly	Monthly	Annually	SOURCE		
						Self	Spouse	Other
Salaries and Gross Wages/Tips								
Income from business/self-employe Dependents								
Income from Interests/ Dividends/Rents/R al /								
Workmen's Comp (SIIS)								
Social Security								
SSI (Supplemental Security)								
Child Support / Alimony					-l			
Military / Veterans Benefits								

Unemployment Benefits								
Other Family Members								

HOUSEHOLD SIZE: List all household members by NAME, DATE OF BIRTH, AND SOCIAL SECURITY NUMBER, include yourself:

NAME	DATE of BIRTH	RELATIONSHIP	SOCIAL SECURITY #

PLEASE READ THE FOLLOWING CAREFULLY

I declare that my household's financial status is as listed above. I understand the following:

- Giving false information regarding my household income will be considered fraud.
- Any change in my finances or the number of people in my household must be reported to Amazing Grace Center and a new application must be completed

Applicant's Signature _____ Date _____

You are required to provide proof of listed income in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax (1040-1040 EZ Form) o Paystubs for recent month
- Current bank statement showing direct deposit (SS, SSI, SSD, Fip, Child support) o Printout from office issuing payments (SS, SSI, SSD, unemployment, VA, etc) oPension payments, Veteran's Benefits
- Court order for alimony or child support or printout for child support payments

○ Employer statement for cash wages (must include employer name, address and phone number) o Award letter o Letter from caregiver o Current Federal Income Tax (1040-1040 EZ Form) o Prior year W-2

○ Paystubs for recent month

○ Current bank statement showing direct deposit (SS, SSI, SSD, Fip, Child support)

○Printout from office issuing payments (SS, SSI, SSD, unemployment, VA, etc) ○ Pension payments, Veteran's Benefits o Court order for alimony or child support or printout for child support payments

○ Employer statement for cash wages (must include employer name, address and phone number) ○ Award letter (For organizational subsidy)

○Letter from caregiver (If relatives or other people are helping pay)

○ Self-employed individuals will be required to submit:

- Detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.

○ In special circumstances where none of the above is available, you must provide a signed statement of income, and an explanation of why you are unable to provide independent verification.

Note: Self- declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless.

Office Use Only:

Horizon Recovery 113 Hode Rd Warfield KY 41256 Phone: 606-390-2262 Fax:866-468-0221

Guarantor #: First Name_____ **Last Name:**_____ **MRN**

_____

Application Received/Entered: Date:By:

_____ By: _____

	Yes	N/A	Notes:
Has patient or any household members applied for Medicaid/Medicare/other• assistance?			
Unemployment Declaration Completed?			
Self-Declaration of Income Completed?			

Calculated Annual Income Total: $ _____ Household Size: _____

Sliding Fee Scale Level Approved: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

Reviewed for past dates of service for adjustments: Dyes By: _____ DNA

Patient Notified of SFS Application Status:

ÜAt office/in person Reached patient by phone ÜAttempted by phone/didn't reach patient

Reviewer: [redacted] Date: _____ _____

Poverty Level*	t or < 100%	125%	150% C	175%	200%	above 200%
1	0-$12 490	12,491- $15 613	$15,614-$18 735	$18,736-$21,858	$21,859-$24,980	$24,981+
2	0-$16,910	$16,911-$21,138	$21,139-$25,365	$25,366-$29,593	$29 594-S33 820	$33 821+

3	0-$21 ,330	21 1-$26,663	$26,664-$31 995	3 1 ,996-S37 328	37,329-$42 660	$42 661+
4	0-S25 750	$25,751-$32,188	$32,189-$38 625	38,626-$45 063	$45 064-$51 500	$51,501+
5	o-S30, 170	30,171-S37 713	$37,714-$45 255	45 256-$52,798	52,799-$60 340	$60,341 +
6	0-$34 590	$34,591-$43,238	$43 239-$51 885	$51,886-$60,533	60,534-S69 180	$69,181+
7	0-S39,010	$39,011-$48,763	$48,764-$58,515	58 516-S68,268	68,269-S78 020	$78 021+
8	0-$43 430	43 ,431-$54,288	$54,289-$65 145	$65,146-$76,003	$76,004-$86,860	$86 861+
For each additional person add						
	4,420	$5,525	6,630	7,735	8,840	$8,840

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	Description	Provider Type	Charge Amt	Medicaid Reimbursement Rate
	LABORATORY SERVICES			
	UDS	ALL	21.75	14.48
	BEHAVIORAL SERVICES			
	Assessment	Counselor	115.83	
	Group Counseling	Counselor	9.66 per 15 min/unit	7.21 per unit
	Individual Counseling	Counselor	104.61	69.74
	SUD Case Management	Counselor		19.54 / 15min-unit
	Intensive Out Patient	Counselor	154.56	149.88/Day
	MEDICAL SERVICES			
	EM New Patient (45 min)	MD/DO	282.76	188.51
	EM New Patient (60 min)	MD/DO	355.38	236.92
	EM Est Patient (45 miN)	MD/DO	183.4	122.27
	EM Est Patient (60 min)	MD/DO	249.22	165.15
	EM New Patient (45 min)	CNP	240.34	160.23
	EM New Patient (60 min)	CNP	302.07	201.38
	EM Est Patient (45 min)	CNP	155.89	103.93
	EM Est Patient (60 miN)	CNP	210.57	140.38
	METHADONE INTAKE PLUS 1ST DOSE			
	OTP DOSING SERVICES			
	Methadone Admin		24.57 per day	16.38 per day
	BUP/Naloxone Admin		24.57 per day	16.38 per day
	Extra BUP/Nal - per 1 mg		1.80 per mg	1.20 per mg

FEE SCALE					
L00%	125% B	150% C	175% D	200% E	>200% F
0	0	5	5	5	5
10	10	15	20	20	25
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	15	20	25	25	25
0	15	20	25	25	25
0	15	20	25	25	25
0	15	20	25	25	25
0	15	20	25	25	25
0	15	20	25	25	25
0	15	20	25	25	25
0	15	20	25	25	25
$20	**$36**	**$52**	**$64**	**$65**	**$70**
10	11	12	13	14.00	14.50
16.50	16.50	16.50	16.50	16.50	16.50
	0	0.4	0.4	0.4	0.4

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