

Jasper County Financial Assistance & Sliding Fee Program

We believe everyone deserves access to quality care. If you are uninsured, have a high insurance deductible or if we are out of network with your insurance, you may qualify for a discount based on your household size and income.

SerenityBridge Counseling and Training Center (2026 PATIENT COST PER SESSION)

Fees are based on the 2026 Federal Poverty Guidelines.

Service Provided	(Lower than Tier 1)	Tier 1	Tier 2	Tier 3	Tier 4	(Above Tier 4)
Initial Evaluation (90791)	\$10.00	\$20.00	\$30.00	\$40.00	\$50.00	\$60.00
60-min Therapy (90837)	\$10.00	\$20.00	\$30.00	\$40.00	\$50.00	\$60.00
45-min Therapy (90834)	\$10.00	\$15.00	\$20.00	\$25.00	\$30.00	\$35.00
30-min Therapy (90832)	\$10.00	\$10.00	\$15.00	\$20.00	\$25.00	\$30.00

DO I QUALIFY?

Check your **Monthly Gross Income** (total household income before taxes):

Household Size	Tier 1 (Max)	Tier 2 (Max)	Tier 3 (Max)	Tier 4 (Max)
1 Person	\$1,330	\$1,662	\$1,995	\$2,660
2 People	\$1,803	\$2,254	\$2,705	\$3,607
3 People	\$2,277	\$2,846	\$3,415	\$4,553
4 People	\$2,750	\$3,438	\$4,125	\$5,500

HOW TO APPLY

1. **Request an Application** at the front desk or visit www.serenitybridgectc.org
2. **Provide Proof of Income** (Pay stubs, W-2, or Social Security letter).
3. **Fair Pricing Guarantee:** Eligible patients will never be charged more than the average amount we receive from insurance companies (AGB).

Questions? Speak with our Financial Counselor today or call 877-814-1782

Servicio disponible en español.



Financial Assistance Application (2026)

Section 1: Applicant Information

- **Name:** _____ **Date of Birth:** _____
- **Address:** _____
- **Phone:** _____ **Household Size (Total People):** _____

Section 2: Household Monthly Gross Income

Please list the monthly income before taxes for everyone living in your home.

- **Employment/Wages:** \$ _____
- **Social Security/Disability:** \$ _____
- **Unemployment/Pension:** \$ _____
- **Child Support/Alimony:** \$ _____
- **TOTAL MONTHLY INCOME:** \$ _____

Section 3: Required Documentation

Please attach **one** of the following to this application:

- Most recent 30 days of pay stubs.
- Most recent W-2 or Federal Tax Return.
- Social Security Benefit Award Letter.
- **Self-Declaration:** If you have zero income, please sign our "Statement of No Income" form available at the front desk.

Section 4: Certification

I certify that the information above is true and correct to the best of my knowledge. I understand that if I qualify for assistance, I will not be charged more than the Amounts Generally Billed (AGB) for my care.

Signature: _____ **Date:** _____