Effective 5/01/2019

Updated 10/2022

Sliding Fee Scale Program (SFSP) Application

It is a policy of The Branch Family Institute (BFI) to provide quality behavioral health services to all persons in need of care, regardless of income and / or the inability to pay. Complete this application to participate in the SFSP. BFI use the information provided to determine your eligibility for discounted services. Clients participating in the SFSP will be reassessed for the sliding scale every six months from the date of initial application and will be required to provide updated proof of income at each six month review.

Client Name ___________________________________ Preferred Name _____________________________

Date of Birth ___________________________ Last four digits of social security ________________________

Do you have Private Insurance, Medicare and/or Medicaid?

Yes ☐ No ☐ Not sure ☐

Household Income

A "Household" includes legal children, a civil union partner or married spouse, and legal dependents. Please list the names of individuals in your household and their relation to you. If needed, please use the back of this form for additional space.

Names of individual living in the household (including yourself)	**Relationship to you**
1.	
2.	
3.	
4.	
Total Number of People in Household	

Client Name: ______________________________   **DOB: ___________________________**

Annual Household Income

Source of Income	Self	Partner	Other	Total
Gross, Wages, Salaries, Tips, ETC.				
Social Security SSI or SSDI				
Unemployment Benefits				
Investment Income				
Other				
Total Income				

Please read and sign below

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. ***I understand that I am personally responsible for all charges for behavioral health services delivered by BFI until such time as I have supplied the necessary documentation of income by my second visit or within 60 days of my first visit whichever comes first.*** I understand that I am required to notify The Branch Family Institute if my income level changes or I become insured. If there are changes, I will be re-assessed for the sliding fee scale.

Print Name: ____

Client Signature: ____ Date: _________________________

Guardian Signature (if applicable): ____

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Client Name: ______________________________ **DOB:** ___________________________

For Internal Use Only:

PLEASE USE MOST CURRENT FEDERAL POVERTY GUIDELINES

Documents Submitted:

	Gross, Wages, Salaries, Tips, ETC.	
	Social Security SSI or SSDI	
	Unemployment Benefits	
	Investment Income	
	TANF	
	Other________________________	

- At or Below 100% Pay $10.00 (Nominal Fee)
- 125% Pay 20%
- 150% Pay 40%
- 175% Pay 60%
- 200% Pay 80%
- Above 200% Pay 100% - No Discount

Reviewed By:	
Effective Date:	
Expiration Date:	

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