Hope Health Systems, Inc.

Sliding Fee Scale

Type of Service	Fee - Maximum
Initial Intake	$70.00
Psychiatric Evaluation	$100.00
Medication Management	$40.00 per session
Individual Therapy (30 min session)	$45.00 per session
Individual Therapy (45 min -1 hr session)	$75.00 per session
Group Therapy	$25.00 per person
Family Therapy	$75.00 per session
Family Psychoeducation	$65.00 per session

Sliding scale fees are subject to change*

A sliding scale fee determines how much you pay for services. A scale is a chart that helps us see how much your fee should be and sliding means that fees are not the same for everyone. HHS provides a sliding fee scale for families/patients below 200% FPL, patients above 200% must pay full charge. Families/Patients 101%-200% FPL receive a 20% to 80% discount based on income and Patients below 100% FPL receive a 100% discount with some services requiring a nominal fee ($5-$10). HHS will base program eligibility on a person's ability to pay and will not discriminate based on an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. Clients are re-certified at least once per year. An HHS representative will meet with you to discuss any fees concerning your treatment services here at Hope Health.

The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility. http://aspe.hhs.gov/poverty-guidelines

Required Documentation for Discounts - Clients who decline to offer this information are ineligible for a discount.

- Documentation is required for discounts after the initial visits
- **Proof of Income** (If Employed) One of the Following:
  - o 1040
  - o W2
  - o 2 recent pay stubs
  - o Written statement by employer

- **Proof of Income** (If Unemployed) One of the Following:
  - o Public Assistance check stub/copy
  - o Social Security check stub or letter of award
  - o Completed zero income form
  - o Written statement from friend or relative with whom patient lives (if other forms not available)
  - o Letter of reference from a 501 (c)(3) organization, such as a church (if other forms not available)

- **Proof of Address** One of the following:
  - o Driver's license
  - o MVA ID,
  - o Any document (envelope) recently addressed to patient such as a utility bill
  - o A written statement by relative or friend with whom patient lives

- **Proof of Address** (Immigrants) One of the Following:
  - o Form 1551
  - o Form 194

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NAME OF APPLICANT			PLACE OF EMPLOYMENT	
NAME OF CLIENT/PATIENT			HAVE YOU APPLIED TO MEDICAL ASSISTANCE: ☐YES ☐NO	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

NOTE: Two of the following are required to verify income:

- ❑ Most recent paycheck stub
- ❑ W-2 form
- ❑ Last income tax return
- ❑ Employer verification letter

Or

- ❑ Unemployment/Social Security check stub

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				

Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

My signature below indicates that I certify that the family size and income information shown above is correct and I authorize Complete Wellness to access information that will confirm the income disclosed on this application.

Applicant Name (Print) _____

Applicant Signature _____ **Date**_____

Office Use Only

Client Name:	
Date Approved:	

Sliding Fee Scale: A – 100% Discount B – 80% Discount C – 60% Discount D – 50% Discount E – 20% Discount

Approved Discount:		**Approved by:**	
Approved Discount:		**Approved by:**	
Approved Fee:		**Approved by:**	
Approved Fee:		**Approved by:**	

Verification Checklist	Select one in each group
Identification/Address:	❑ Driver's license ❑ Utility bill ❑ Employment ID ❑ Other
Income:	❑ Prior year tax return ❑ Most recent pay stub ❑ Other
Insurance:	❑ Insurance Card