**Rawlings Community Counseling**

**Family Assistance Plan Application**

|  |  |
| --- | --- |
| **NAME OF HEAD OF HOUSEHOLD** | **PLACE OF EMPLOYMENT** |
| **HEALTH INSURANCE PLAN** | **SOCIAL SECURITY NUMBER** |

Please list spouse and dependents under age 18

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Name** | **Date of Birth** |
| SELF |  | DEPENDENT |  |
| SPOUSE |  | DEPENDENT |  |
| DEPENDENT |  | DEPENDENT |  |
| DEPENDENT |  | DEPENDENT |  |

Annual Household Income

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Self** | **Spouse** | **Other** | **Total** |
| Gross wages, salaries, tips, etc |  |  |  |  |
| Social security, pension, annuity, and veteran’s benefits |  |  |  |  |
| Alimony, child support, military family allotments |  |  |  |  |
| Income from business self employment, and dependents |  |  |  |  |
| Rent, interest, dividend, and other income |  |  |  |  |
| **Total Income** |  |  |  |  |

Pro-bono Policy:

Eligible clients will receive 5 pro-bono sessions then be reassessed for additional sessions if applicable. Clients must meet three of following requirements to participate:

* Currently homeless with no future living placement
* Currently unemployed with no future employment in place
* Currently at or below 100% 2013 federal poverty level
* Have significant medical, legal or cost of living expenses that impose a actual threat to basic survival as evidenced by monthly sums that interfere with food and/or shelter
* A single parent with a minor(s) below the age of 18
* Incarcerated within the last 30 days
* No insurance coverage for the services being provided, high deductible, or services are not covered

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

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|  |

Name (Print) Date

|  |
| --- |
|  |

Signature

**Office Use Only**

|  |  |
| --- | --- |
| PATIENT NAME | DISCOUNT |
| START DATE | APPROVED BY |
| Verification Checklist (attach copies   |  |  | | --- | --- | |  | Tax Return | |  | 3 most recent pay stubs | |  | Other | | |

**2013 Federal Poverty Guideline - 48 Contiguous States and DC**

Services will be provided regardless of your ability to pay. Medicare clients can participate in the sliding fee scale deduction and the cost of the deductible discounted based off of the poverty guidelines below.

The SFS or discounted fee schedule is based upon the Federal Poverty Guidelines, and patient eligibility is determined by annual income and family size designed specifically for individuals with annual incomes at or below 100% of the HHS Poverty Guidelines (see table below). If a patient meets the below criteria and has a third party payer (either public or private), an NHSC-approved site will bill the third party payer for services and the patient will be responsible for remaining costs at the rate the SFS.

Note: The 100% column shows the federal poverty level for each family size, and the percentage columns that follow represent income levels that are commonly used as guidelines for health programs.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Household Size** | **CPT Codes**  2 hr Group  3 hr Group  50 min Ind & Fam  60+ min Ind & Fam  Assessments | **100%**  **$20**  **$25**  **$35**  **$40**  **$45** | **133%**  **$20**  **$25**  **$45**  **$50**  **$55** | **150%**  **$25**  **$30**  **$55**  **$60**  **$65** | **200%**  **$30**  **$35**  **$65**  **$70**  **$75** | **250%**  **$35**  **$45**  **$75**  **$80**  **$85** | **300%**  **Full** | **400%**  **Full** |
| 1 |  | $11,490 | $15,282 | $17,235 | $22,980 | $28,725.00 | $34,470 | $45,960 |
| 2 |  | 15,510 | 20,628 | 23,265 | 31,020 | $38,775.00 | 46,530 | 62,040 |
| 3 |  | 19,530 | 25,975 | 29,295 | 39,060 | $48,825.00 | 58,590 | 78,120 |
| 4 |  | 23,550 | 31,322 | 35,325 | 47,100 | $58,875.00 | 70,650 | 94,200 |
| 5 |  | 27,570 | 36,668 | 41,355 | 55,140 | $68,925.00 | 82,710 | 110,280 |
| 6 |  | 31,590 | 42,015 | 47,385 | 63,180 | $78,975.00 | 94,770 | 126,360 |
| 7 |  | 35,610 | 47,361 | 53,415 | 71,220 | $89,025.00 | 106,830 | 142,440 |
| 8 |  | 39,630 | 52,708 | 59,445 | 79,260 | $99,075.00 | 118,890 | 158,520 |
| For each additional person, add  $4020 |  |  |  |  |  |  |  |  |

In order to participate in the “Sliding Fee Discount Program,” proof of income is required within ten (10) days of first visit. Proof of income will also be required annually from the date of the first visit. Until this proof of income is received, all visits will be billed at full price, adjustments can be made at the time of receipt of the proof of income.

I hereby agree that the above information is true and correct to the best of my knowledge.

**Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

I have read the above information on the sliding fee discount program and choose to opt out.

**Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**