SLIDING FEE SCALE APPLICATION

It is the policy of Champion State of Mind, PLLC to provide essential services regardless of the client's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

How do I qualify?

All applicants are asked to provide proof of household income and family size to qualify for discounted fees. Information will be updated at least once a year, or anytime your income, household size and/or medical insurance status changes. If it the client's (or legal guardian's) responsibility to keep an up-to-date sliding scale application with Champion State of Mind, PLLC.

Processing of Application

Upon receiving a completed Sliding Scale Fee Application, Champion State of Mind, PLLC will review the application request and notify the client of his or her eligibility. Note that U.S. Poverty Guidelines and the Sliding Fee Discount grid (shown below) will be used to determine eligibility. A completed application includes the following: the current form with date/signature, the Sliding Fee Scale Application and all supporting documentation to verify the reported income**.** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with Champion State of Mind, PLLC. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application. Champion State of Mind, PLLC requires that clients otherwise eligible for 100% discount pay a nominal fee of $5.00 per session visit.

Poverty Level[1]	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	Discount 100%	Discount 100%	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 10%	Discount 0%
1	12,760	14,036	15,312	16,588	17,864	19,140	20,416	21,692	22,968	24,244	25,520	25,521+
2	17,240	18,964	20,688	22,412	24,136	25,860	27,584	29,308	31,032	32,756	34,480	34,481+
3	21,720	23,892	26,064	28,236	30,408	32,580	34,752	36,924	39,096	41,268	43,440	43,441+
4	26,200	28,820	31,440	34,060	36,680	39,300	41,920	44,540	47,160	49,780	52,400	52,401+
5	30,680	33,748	36,816	39,884	42,952	46,020	49,088	52,156	55,224	58,292	61,360	61,361+
6	35,160	38,676	42,192	45,708	49,224	52,740	56,256	59,722	63,288	66,804	70,320	70,321+
7	39,640	43,604	47,568	51,532	55,496	59,460	63,424	67,388	71,352	75,316	79,280	79,281+
8	44,120	48,532	52,944	57,356	61,768	66,180	70,592	75,004	79,416	83,828	88,240	88,240+
For each additional person, add	4,480	4,928	5,376	5,824	6,272	6,720	7,168	7,616	8,064	8,512	8,960	8,960

[1] Based on 2020 Federal Poverty Guidelines.

SLIDING FEE SCALE APPLICATION FORM

NOTE: To comply with federal regulations and in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least once a year. Please bring yearly income tax return, copy of your W-2 form, last three paycheck stubs, copies of your social security checks, or other checks you may receive as proof of your family income. Only The family size and annual income will be used to determine your eligibility and to calculate your discount.

Name of Head of Household: _____

Home street address: _____ **Apt.:** _____

Mailing address (if different from street address): _____

City: _____ **State:** _____ **Zip:** _____

Home phone: _____ **Cell phone:** _____

Place of Employment: _____

Please list spouse and dependents under the age of 18:

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual House Income:

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc...				
Income from business, self-employment, and dependants				
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				

I (Insert Name: _____) do hereby swear or affirm that the information provided in this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee scale and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Champion State of Mind, PLLC if there is a significant change in my income. If qualification for the sliding fee scale is obtained under this application, I will comply with all rules and regulations of Champion State of Mind, PLLC. I understand that the information provided will be kept confidential except for the purposes of this form and will not be released without my written permission. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____

Name (Print):_____

Signature: _____

OFFICE USE ONLY:

Application returned (Date): _____

Total Annual Income: _____ # of Household Size: _____

Verified with: ☐ Three most recent pay stubs ☐ Prior year tax return ☐ Other: _____

Identification/Address: ☐ Driver's License ☐ Utility Bill ☐ Employment ID ☐ Other: _____

Insurance: ☐ Insurance Cards

Discount Effective Date: _____

Qualified? ☐ Yes ☐ No

Discount Percentage (Per Session): _____

Requalify Date (if applicable): _____

Date: _____

Approved By- Signature: _____

Employee Name (Print): _____