SLIDING FEE DISCOUNT APPLICATION

It is the policy of Advantage Behavioral Healthcare to provide essential services regardless of the member's ability to pay. Advantage Behavioral Healthcare offers discounts 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 outpatient essential services received at Advantage Behavioral Healthcare, but not those services or equipment purchased from outside. You must complete this form every 12 months or if your financial situation changes.

Date: _____

Name: _____ Phone #: _____

Street Address: _____

City: _____ State:_____ Zip Code: _____

Member's Proof of Address:

☐ Driver's License ☐ Employment ID ☐ Other (explain): _____

☐ Any document recently addressed to member such as a utility bill

Please list all household members, including those under age 18.

	Name	Date of Birth
Self		
Other		
Other		
Other		
Other		
Other		

Advantage BEHAVIORAL HEALTHCARE, INC

Household Income

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans payment, survivor benefits, pension or retirement income			
Interest, dividends, royalties, income from rental properties, estates, alimony, child support, assistance from outside the household, etc.			
Total Income			

Proof of Income:

☐ Three most recent pay stubs ☐ Unemployment Award Letter ☐ Current W2 and 1099
☐ Prior Year Tax Return ☐ Child Support Income ☐ Alimony Income
☐ Social Security/SSI Award Letter/Copy of Recent Check ☐ Pension Statement
☐ Disability Award Notice

I certify that the family size and income information above is accurate

_____
(Print Name)

_____ _____
(Signature of Member/Guardian) (Date)

_____ _____
(Signature of Witness) (Date)

Office Use Only

Patient Name: _____ Approved Discount: _____

Approved by: _____ Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		

Advantage Behavioral Healthcare has explained to me my financial responsibility. My co-pay for service is listed below based on my current income and family size. I understand that periodic reviews of fees will be performed and I understand that I must bring in current income documentation when requested and annually.

Co-Insurance/Co-Payment Amount:

☐ Service Code:_____

☐ Service Code:_____

☐ Service Code:_____

☐ Service Code:_____

☐ Service Code:_____

_____ _____

(Signature of Member/Guardian) (Date)

_____ _____

(Signature of Witness) (Date)

Office Use Only

Total Household Income: _____ Total Household Family Members: _____

Sliding Fee Co-Payment: _____ Service Code: _____

Sliding Fee Co-Payment: _____ Service Code: _____

Sliding Fee Co-Payment: _____ Service Code: _____

Sliding Fee Co-Payment: _____ Service Code: _____

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