COMMUNITY CARE ALLIANCE

Client Insurance Information

Date: _____

Client Name:_____ HI #: _____

Application for Sliding Fee Scale

- ☐ Paycheck Stub (most recent 4 weeks)
- ☐ W-2 Form
- ☐ Last Income Tax Return

For Uninsured/Underinsured ONLY

- ☐ Unemployment Check Stub
- ☐ Social Security Check Stub
- ☐ Written Statement from Employer

To be used only if there is not written income verification

- ☐ Self-Declaration of Income
- ☐ IRS Form 4506T-EZ

Income Provided: _____

Based on the information provided, you qualify for a Sliding Scale Fee/Discount of _____.

I presently have no insurance or my insurance does not provide benefits for behavioral health services needed. I am applying for a Sliding Fee Discount. I have provided the above documents. I understand that I am responsible for fees in full at the time of each service. If payment is not made, this could interrupt services until payment is made. Should I enroll in insurance, I will inform the agency with this information prior to my next session. I understand that if the information is not received by the agency in a timely manner, I will be responsible for all charges that are deemed un-reimbursable by the insurance plan.

Sliding Scale Discount Schedule Based on Household Income and 2020 Federal Poverty Guidelines

	Gross Annual Household Income												
Household Size	**$10 Flat Fee**			**25% Charge**			**50% Charge**			**75% Charge**			**100% Charge**
1	$0	to	$12,760	$12,761	to	$15,775	$15,776	to	$18,790	$18,791	to	$24,820	$24,821+
2	$0	to	$17,240	$17,241	to	$21,300	$21,301	to	$25,360	$25,361	to	$33,480	$33,481+
3	$0	to	$21,720	$21,721	to	$26,825	$26,826	to	$31,930	$31,931	to	$42,140	$42,141+
4	$0	to	$26,200	$26,201	to	$32,350	$32,351	to	$38,500	$38,501	to	$50,800	$50,801+
5	$0	to	$30,680	$30,681	to	$37,875	$37,876	to	$45,070	$45,071	to	$59,460	$59,460+
6	$0	to	$35,160	$35,161	to	$43,400	$43,401	to	$51,640	$51,641	to	$68,120	$68,121+
7	$0	to	$39,640	$39,641	to	$48,925	$48,926	to	$58,210	$58,211	to	$76,780	$76,781+
8	$0	to	$44,320	$44,321	to	$54,450	$54,451	to	$64,780	$64,781	to	$85,440	$85,441+
For each additional person add $4,480													

See attached Rates

STANDARD AGENCY RATES

Billing Code	Service Type	MD	PCNS	RN	LICSW/LCSW	LMHC/LMFT	PC/COUN	LCDP/LCDS
90791	BPSA	X	X	$124.00	$131.75	$131.75	$116.25	$108.50
90792	Psych Evaluation	$294.35	$250.20	x	X	X	X	X
90833	30 min psychotherapy w/ eval & med mngmt	$42.00	$37.50	x	X	X	X	X
90838	60 min psychotherapy w/ eval & med mngmt	$100.00	$85.00	x	X	X	X	X
90832	Psychotherapy 16-37 mins	X	X	x	$52.50	$52.50	$49.00	$45.50
90834	Psychotherapy 38-52 mins	X	X	x	$72.00	$72.00	$67.20	$62.40
90837	Psychotherapy 53-999 mins	X	X	x	$75.00	$75.00	$70.00	$65.00
99211	RN check in eval & management 5 minute units	x	X	$7.50	X	X	X	X
99212	Med Visit 10 mins	$56.00	$47.60	x	X	X	X	X
99213	Med Visit 15 mins	$78.00	$66.30	x	X	X	X	X
92214	Med Visit 25 mins	$118.00	$100.30	x	X	X	X	X
99215	Med Visit 40 mins	$148.00	$125.80	x	X	X	X	X
90846	Family psychotherapy w/o patient	$90.00	$76.50	X	$67.50	$67.50	$63.00	$58.50
90847	Family psychotherapy w/patient	$96.00	$81.60	X	$72.00	$72.00	$67.20	$62.40
90853	Group psychotherapy	$48.00	$40.80	X	$36.00	$36.00	$33.60	$31.20
H0036	Casemanagement per 15 min	$16.00	$16.00	$16.00	$16.00	$16.00	$16.00	$16.00
H0037	IHH per day	$13.82	$13.82	$13.82	$13.82	$13.82	$13.82	$13.82
H0040	ACT per day	$41.65	$41.65	$41.65	$41.65	$41.65	$41.65	$41.65
H0906	Intensive OP (IOP) per day	$180.00	$180.00	$180.00	$180.00	$180.00	$180.00	$180.00
H0912	Partial Hosp. (PHP) per day	$260.00	$260.00	$260.00	$260.00	$260.00	$260.00	$260.00

According to the charts above, your personal charges for the following providers will be:

SERVICE	CURRENT CHARGE	MY PERCENT OF PAYMENT	MY PAYMENT
Med Visit 15 min PCNS *(EXAMPLE)*	**$66.30**	**50%**	**$33.15**
LICSW 60 min *(EXAMPLE)*	**$75.00**	**25%**	**$56.25**

I understand that if I require any additional types of service I will be informed in writing in advance of the service being provided.

_____ _____

Client or Guardian Signature Date

_____ _____

CCA Representative Signature Date

_____

CCA Representative Printed Name