COMMUNITY CARE ALLIANCE

(Rev. 3/2021)

Application for Sliding Fee Scale (For Uninsured ONLY)

Date: _____

Client Name:_____ HI #: _____

Application for Sliding Fee Scale **For Uninsured/Underinsured ONLY**

- ☐ Paycheck Stub (most recent 4 weeks)
- ☐ W-2 Form
- ☐ Last Income Tax Return
- ☐ 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 2021 Federal Poverty Guidelines

	Gross Annual Household Income												
Household Size	**$10 Flat Fee**			**25% Charge**			**50% Charge**			**75% Charge**			**100% Charge**
1	$0	to	$12,880	$12,881	to	$16,100	$16,101	to	$19,320	$19,321	to	$25,760	$25,760+
2	$0	to	$17,420	$17,421	to	$21,775	$21,776	to	$26,130	$26,131	to	$34,840	$34,840+
3	$0	to	$21,960	$21,961	to	$27,450	$27,451	to	$32,940	$32,941	to	$43,920	$43,920+
4	$0	to	$26,500	$26,501	to	$33,125	$33,126	to	$39,750	$39,751	to	$53,000	$53,000+
5	$0	to	$31,040	$31,041	to	$38,800	$38,801	to	$46,560	$46,561	to	$62,080	$62,080+
6	$0	to	$35,580	$35,581	to	$44,475	$44,476	to	$53,370	$53,371	to	$71,160	$71,160+
7	$0	to	$40,120	$40,121	to	$50,150	$50,151	to	$60,180	$60,181	to	$80,240	$80,240+
8	$0	to	$44,600	$44,601	to	$55,750	$55,751	to	$66,900	$66,901	to	$89,200	$89,200+
For each additional person add $4,540													

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. I also understand it is my obligation to inform CCA of any changes in my income and or insurance status.

_____ _____

Client or Guardian Signature Date

_____ _____

CCA Representative Signature Date

_____

CCA Representative Printed Name