

COMMUNITY CARE ALLIANCE

(Rev. 01/25)

Application for Sliding Fee Scale (For Uninsured ONLY)

Date: _____

Client Name: _____ HI #: _____

Application for Sliding Fee Scale For Uninsured/Underinsured ONLY

- | | |
|--|--|
| <input type="checkbox"/> Paycheck Stub (most recent 4 weeks) | <input type="checkbox"/> Unemployment Check Stub |
| <input type="checkbox"/> W-2 Form | <input type="checkbox"/> Social Security Check Stub |
| <input type="checkbox"/> Last Income Tax Return | <input type="checkbox"/> Written Statement from Employer |

To be used only if there is not written income verification

- | | |
|---|--|
| <input type="checkbox"/> Self-Declaration of Income | <input type="checkbox"/> 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 2024 Federal Poverty Guidelines:

Household Size	Gross Annual Household Income												100% Charge
	Tier 1			Tier 2			Tier 3			Tier 4			
1	\$0	to	\$15,060	\$15,061	to	\$18,825	\$18,826	To	\$22,590	\$22,591	to	\$26,355	\$30,120 +
2	\$0	to	\$20,440	\$20,441	to	\$25,550	\$25,551	To	\$30,660	\$30,661	to	\$35,770	\$40,880 +
3	\$0	to	\$25,820	\$25,821	to	\$32,275	\$32,276	To	\$38,730	\$38,731	to	\$45,185	\$51,640 +
4	\$0	to	\$31,200	\$31,201	to	\$39,000	\$39,001	To	\$46,800	\$46,801	to	\$54,600	\$62,400 +
5	\$0	to	\$36,580	\$36,581	to	\$45,725	\$45,726	To	\$54,870	\$54,871	to	\$64,015	\$73,160 +
6	\$0	to	\$41,960	\$41,961	to	\$52,450	\$52,451	To	\$62,940	\$62,941	to	\$73,430	\$83,920 +
7	\$0	to	\$47,340	\$47,341	to	\$59,175	\$59,176	To	\$71,010	\$71,011	to	\$82,845	\$94,680 +
8	\$0	to	\$52,720	\$52,721	to	\$65,900	\$65,901	To	\$79,080	\$79,081	to	\$92,260	\$105,440 +
	Add \$5,380 for each additional person			Add \$6,725 for each additional person.			Add \$8,070 for each additional person.			Add \$9,415 for each additional person.			

STANDARD AGENCY RATES:

Service	Billing Code	Tier 1	Tier 2 (25%)	Tier 3 (50%)	Tier 4 (75%)	100% Charge
Assessment	90791	\$20.00	\$50.00	\$100.00	\$150.00	\$200
Case Management	H0036	\$2.50 per 15 minute unit	\$6.00 per 15 minute unit	\$12.50 per 15 minute unit	\$19.00 per 15 minute unit	\$25.00 per 15 minute unit
Case Management Group	H0036	\$2.50	\$9.00	\$17.50	\$26.00	\$35.00
Crisis Evaluation	H2011	\$10	\$10.50 per 15 minute unit	\$21.00 per 15 minute unit	\$31.50 per 15 minute unit	\$42.00 per 15 minute unit
Group Counseling	90853	\$3.50	\$12.50	\$25.00	\$37.50	\$50.00
Individual Counseling 30-45 minutes (length of session as clinically indicated)	90832 90834	\$5.00	\$22.50-29.00	\$45.00-57.50	\$67.50-86.00	\$90.00 \$115.00
Individual Counseling 60 minutes (length of session as clinically indicated)	90837	\$5.00	\$43.00	\$86.00	\$129.00	\$172.00
Nurse Case Management	H0036	\$2.50 per 15 minute unit	\$6.00 per 15 minute unit	\$12.50 per 15 minute unit	\$19.00 per 15 minute unit	\$25.00 per 15 minute unit
Nursing Assessment	90791 TD	\$10.00	\$50.00	\$100.00	\$150.00	\$200.00
Nursing Injection	99211 TD	\$2.50	\$2.50 per 5 minute unit	\$5.00 per 5 minute unit	\$7.50 per 5 minute unit	\$10.00 per 5 minute unit
Nursing Visit	99211 TD	\$5.00	\$2.50 per 5 minute unit	\$5.00 per 5 minute unit	\$7.50 per 5 minute unit	\$10.00 per 5 minute unit
Peer Support Group	H0038 U2 HQ	\$2.50	\$1.00 per 15 minute unit	\$2.00 per 15 minute unit	\$3.50 per 15 minute unit	\$4.71 per 15 minute unit
Peer Support	H0038 U2	\$2.50 per 15 minute unit	\$4.00 per 15 minute unit	\$8.00 per 15 minute unit	\$12.00 per 15 minute unit	\$16.23 per 15 minute unit
Psychiatric Assessment	90792	\$25.00	\$79.00	\$157.50	\$236.00	\$315.00
Substance Case Management	H0036 HN	\$2.50 per 15 minute unit	\$6.00 per 15 minute unit	\$12.50 per 15 minute unit	\$19.00 per 15 minute unit	\$25.00 per 15 minute unit
Vocational Case Management	H2023	\$2.50 per 15 minute unit	\$6.00 per 15 minute unit	\$12.50 per 15 minute unit	\$19.00 per 15 minute unit	\$25.00 per 15 minute unit
Care Coordination	H0046	--	--	--	--	\$8.00 per 15 minute unit
Care Management < 15 minutes	H0046	\$1.00	\$2.00	\$4.00	\$6.00	\$8.00
Medication Reconciliation	H0046	--	--	--	--	\$8.00 per 15 minute unit
Supplemental Service – Outreach & Engagement	H0046	--	--	--	--	\$8.00 per 15 minute unit
Prescriber Visit – Standard (based on prescriber findings – non-negotiable)	99212 99213	\$10.00	\$16.00-24.00	\$32.50-47.50	\$49.00-71.00	\$65.00 \$95.00
Prescriber Visit – Complex (based on prescriber findings – non-negotiable)	99214 99215	\$15.00	\$35.00-50.00	\$70.00-100.00	\$105.00-150.00	\$140.00 \$200.00
Prescriber add Counseling (when clinically necessary)	90833	\$5.00	\$22.50	\$45.00	\$67.50	\$90.00
CIS/EOS Case Management	H0004 H0036	\$3.00 per 15 minute unit	\$7.50 per 15 minute unit	\$15.00 per 15 minute unit	\$22.50 per 15 minute unit	\$30.00 per 15 minute unit
CIS/EOS Counseling	H0036	\$4.00 per 15 minute unit	\$10.00 per 15 minute unit	\$20.00 per 15 minute unit	\$30.00 per 15 minute unit	\$40.00 per 15 minute unit
IOP Day	H0015	\$10.00 per day	\$50.00 per day	\$100.00 per day	\$150.00 per day	\$200.00 per day

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.

Billing Staff only:

Income updated and verified

Approved-Date: _____

Denied-Reason.

Client or Guardian Signature

Date

CCA Representative Printed Name

CCA Representative Signature

Date