

**COMMUNITY CARE ALLIANCE**

(Rev. 7/23)

**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 2023 Federal Poverty Guidelines**

Household Size	Gross Annual Household Income												
	\$10 Flat Fee			25% Charge			50% Charge			75% Charge			100% Charge
1	\$0	to	\$13,590	\$13,591	to	\$16,988	\$16,989	to	\$20,385	\$20,386	to	\$23,783	\$27,180+
2	\$0	to	\$18,310	\$18,311	to	\$22,888	\$22,889	to	\$27,465	\$27,466	to	\$32,043	\$36,620+
3	\$0	to	\$23,030	\$23,031	to	\$28,788	\$28,789	to	\$34,545	\$34,546	to	\$40,303	\$46,060+
4	\$0	to	\$27,750	\$27,751	to	\$34,688	\$34,689	to	\$41,625	\$41,626	to	\$48,563	\$55,500+
5	\$0	to	\$32,470	\$32,471	to	\$40,588	\$40,589	to	\$48,705	\$48,706	to	\$56,823	\$64,940+
6	\$0	to	\$37,190	\$37,191	to	\$46,488	\$46,489	to	\$55,785	\$55,786	to	\$65,083	\$74,380+
7	\$0	to	\$41,910	\$41,911	to	\$52,388	\$52,389	to	\$62,865	\$62,866	to	\$73,343	\$83,820+
8	\$0	to	\$46,630	\$46,631	to	\$58,288	\$58,289	to	\$69,945	\$69,946	to	\$81,603	\$93,260+

For each additional person add \$4,540 to annual income.

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	\$300.00	\$250.20	X	X	X	X	X
90833	30 min psychotherapy w/ eval & med mngmt	\$65.00	\$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	Case Management 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
H2023	Vocational CM/Supported Employment	\$21.25	\$21.25	\$21.25	\$21.25	\$21.25	\$21.25	\$21.25
H0036 HN	Substance Abuse Case Management	\$21.25	\$21.25	\$21.25	\$21.25	\$21.25	\$21.25	\$21.25

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

SERVICE	CURRENT CHARGE	MY PERCENT OF PAYMENT	MY PAYMENT
<i>Med Visit 15 min PCNS (EXAMPLE)</i>	<i>\$66.30</i>	<i>50%</i>	<i>\$33.15</i>
<i>LICSW 60 min (EXAMPLE)</i>	<i>\$75.00</i>	<i>25%</i>	<i>\$18.75</i>

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 Printed Name

\_\_\_\_\_  
CCA Representative Signature Date

Billing Staff only:

Income updated and verified

Approved-Date: \_\_\_\_\_

Denied-Reason: \_\_\_\_\_

Billing Staff Initials: \_\_\_\_\_