



Sliding Fee Scale Requirements and Application

General Rules

- Discount must be offered to all patients who meet eligibility criteria
- Eligibility criteria must be developed from the Federal Poverty Guidelines, based on family size and income
- Discounts will be all inclusive, covering visits, procedures, etc. per unit of service for any service available at the time the family is enrolling in services (not all services may be available)
 - Psychological/Neuropsychological Services – 1-hr units
 - Behavioral Health – 1-hr units
 - Occupational Therapy – 15-minute units (Evaluations – 1-hr units)
 - Speech Therapy – 15-minute units (Evaluations – 1-hr units)
 - Physical Therapy – 15-minute units (Evaluations – 1-hr units)

Fee Scale

- Clients between 0 -200% Federal Poverty Level might qualify to receive a discount
- All individuals who are uninsured, under-insured, or been denied for services may also qualify
- Clients may be responsible for a nominal fee for services. This will be determined by the fee schedule.

Determining Eligibility for Discounts

- The collection of family size and income information from client(s) is required
- Clients who decline to offer this information are ineligible for a discount
- The client(s) will be provided the application form to have completed or to bring the necessary documentation prior to the initial appointment.
 - Support staff, the clinician, or other representative from the BRAINS Foundation will review the information and determine the fee(s) for service.
- The application for fee adjustment may be reviewed every 6-months or annually, but is required annually.

Recertifying Clients for Discount

- Clients are re-certified once per year, or 6 months depending on the circumstances

The following documents are attached to this memo

- Discount Application Form
 - Form must be completed prior to initial registration & updated as requested
- Sliding fee scale & costs for services prior to consideration according to Federal Poverty Guidelines

Other Protocol

- Family must complete appropriate intake paperwork required for clinical practice following agreement to services.



Required Documentation for Discounts

- Discount Application Form
- Proof of Income please provide one of the following:
 - If Employed
 - 1040
 - W2
 - 2-months of recent pay stubs
 - Written statement by employer for change in status of income or coverage
 - If Unemployed
 - Public Assistance check stub/copy
 - Social Security check stub or letter of award
 - Certification Letter from Medical Assistance or Department of Social Services
 - Completed zero income form
 - Written statement from friend or relative with whom patient lives (if other forms not available)
 - Letter of reference from a 501 (c)(3) organization, such as a church (if other forms not available)
- Proof of Address please provide one of the following:
 - US Citizen
 - Driver's license
 - Verification of legal address via phone book, letter from homeless or abuse shelter
 - Any document (envelope) recently addressed to patient such as a utility bill
 - A written statement by relative or friend with whom patient lives
 - Immigrants
 - Form 1551
 - Form 194



Discount Application Form

Date of Completion _____	Referral Source: _____
Patient Name _____ DOB _____ Race _____ Sex _____	
Address _____	
City _____ State _____ Zip Code _____	
*Please complete the section below if you are over 18 years of age	
Guardian/Parent Name: _____ DOB _____ Race _____ Sex _____	
Driver's License No. _____ SS# _____	
Phone Numbers: Home _____ Office _____ Cell _____	
Place(s) of employment _____ Occupation/Trade _____	
*Please complete the section below if there is more than one person contributing to income	
Guardian/Parent Name: _____ DOB _____ Race _____ Sex _____	
Driver's License No. _____ SS# _____	
Phone Numbers: Home _____ Office _____ Cell _____	
Place(s) of employment _____ Occupation/Trade _____	
Combined Annual Income _____	

OFFICE USE ONLY

You understand you have a financial responsibility for services. This contract will be valid for a minimum of 6-months, but up to a one year period of eligibility starting on _____. You will need to be re-qualified for services on my anniversary date, which is _____. You understand you must bring in current documentation at the point of my annual anniversary.

Patient / Guardian Signature _____

Staff Signature _____ Date Signed _____



Number of persons living in your household: _____

Person(s) contributing to income: _____

Household Member(s) Household Income (Complete relevant column(s))

	Self	Spouse	Relative (providing Financial Support/amount)	Other Source(s) and amount of income
Annual Income				
Monthly Income				
Bi-Weekly Income				
Other Income				

**Supporting proof of documented income required*

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved and will be provided as may be requested.

Name (Print)

Signature

Date

Office Use Only			
Client Name: _____	Fee for Service(s): _____	Service: _____	Fee: _____
Service: _____	Fee: _____	Service: _____	Fee: _____
Date of Service: _____	Approved By: _____		



Behavioral Resources and Institute for Neuropsychological Services Foundation Fee Schedule

Sliding Fee Scale
Based on 2009 Federal Poverty Guidelines

Family Size	100% Discount *		80% Discount		60% Discount		40% Discount		20% Discount	
	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
1	\$0	\$ 10,830	\$ 10,831	\$ 13,538	\$ 13,539	\$ 16,245	\$ 16,246	\$ 18,953	\$ 18,954	\$ 21,660
2	\$0	\$ 14,570	\$ 14,571	\$ 18,213	\$ 18,214	\$ 21,855	\$ 21,856	\$ 25,498	\$ 25,499	\$ 29,140
3	\$0	\$ 18,310	\$ 18,311	\$ 22,888	\$ 22,889	\$ 27,465	\$ 27,466	\$ 32,043	\$ 32,044	\$ 36,620
4	\$0	\$ 22,050	\$ 22,051	\$ 27,563	\$ 27,564	\$ 33,075	\$ 33,076	\$ 38,588	\$ 38,589	\$ 44,100
5	\$0	\$ 25,790	\$ 25,791	\$ 32,238	\$ 32,239	\$ 38,685	\$ 38,686	\$ 45,133	\$ 45,134	\$ 51,580
6	\$0	\$ 29,530	\$ 29,531	\$ 36,913	\$ 36,914	\$ 44,295	\$ 44,296	\$ 51,678	\$ 51,679	\$ 59,080
7	\$0	\$ 33,270	\$ 33,271	\$ 41,588	\$ 41,589	\$ 49,905	\$ 49,906	\$ 58,223	\$ 58,224	\$ 66,540
8	\$0	\$ 37,010	\$ 37,011	\$ 46,263	\$ 46,264	\$ 55,515	\$ 55,516	\$ 64,768	\$ 64,769	\$ 74,020
9	\$0	\$ 40,750	\$ 40,751	\$ 50,938	\$ 50,939	\$ 61,125	\$ 61,126	\$ 71,313	\$ 71,314	\$ 81,500
10	\$0	\$ 44,230	\$ 44,231	\$ 55,288	\$ 55,289	\$ 66,345	\$ 66,346	\$ 77,403	\$ 77,404	\$ 88,460
% of Poverty	100%		125%		150%		175%		200%	
Plan Code	904		903		902		901		900	

For Family Units with more than 10 members, for each additional member add \$3,480.

COSTS FOR SERVICES PRIOR TO SLIDING FEE SCALE:

Service	Charge
<u>Neuropsychological Services</u>	
Initial NP Evaluation	\$150.00/hr
Neuropsych Testing	\$100.00/hr
Neurobehavioral Exam	\$150.00/hr
<u>Psychological Services</u>	
Initial Psychological Evaluation (Pre-Doctoral)	\$150.00/hr
Psychological Testing	\$100.00/hr
Learning Disability Testing	\$100.00/hr
Therapy 20-30 minutes (Doctoral)	\$50.00
Therapy 45-50 minutes (Doctoral)	\$100.00/hr
Consultation with External Agency	\$100.00/hr (negotiable)
Groups/workshops (per client)	\$35.00/hr
Parenting Groups	Variable
Paperwork/correspondence (after initial report)	\$10.00/per 15-minute
School – On-site	\$100.00/hr
Phone Consultation – self-pay only	\$15.00/per 15-minute
Anticipated future offerings not currently available as of 6-1-09	
Physical Therapy	
Occupational Therapy	
Speech Therapy	