Neuropsychology, Psychiatry, and Behavioral Health Services
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SLIDING FEE DISCOUNT PROGRAM APPLICATION

Mountain West Psychological Resources (MWPR) is committed to providing affordable and quality services to our community. Our Sliding Fee Discount Program (SFDP) is designed to provide no cost or discounted cost to those who have fewer means to pay for their psychiatric and/or behavioral health services. The SFDP is available to all individuals and families with annual income at or below 200 percent of the most current Federal Poverty Guidelines. Participation in this program is solely determined by a patient's family size and income.

Eligibility for the program is determined by documented annual income and family/household size only. If approved, the date the application and required documentation was initially submitted will be considered the start date for the sliding fee discounts. Please note that all required income documents must be received within 14-days from the date that this application was submitted. If the necessary documentation is not provided within 14-days, the application approval date will be re-dated to the date on which the required information is received. Any fees incurred prior to the application being approved will not be covered under the SFDP.

If at any time during this application process you need assistance, please feel free to contact our Patient Account Representative or Receptionist at Mountain West Psychological Resources.

APPLICATION STATUS: ☐ New Application ☐ Change in Income ☐ Renewal

PATIENT INFORMATION:

_____ _____-_____-_____ ____/____/____
First MI Last Social Security # Date of Birth

_____-_____-_____ _____
Primary Phone # Mailing Address City State Zip

RESPONSIBLE PARTY:

_____ _____-_____-_____ ____/____/____
First MI Last Social Security # Date of Birth

_____-_____-_____ _____
Primary Phone # Mailing Address City State Zip

INSURANCE INFORMATION: MWPR will make reasonable efforts to collect alternate payment resources for services rendered, including from third-party insurance carriers, as well as federal and state programs (**responses are optional*):

*Does the patient have Medicaid coverage? ☐ Yes ☐ No
- If No, does the patient wish to have assistance in applying? ☐ Yes ☐ No

*Does the patient have other health insurance coverage? ☐ Yes ☐ No
- If yes, please list insurance carrier and provide insurance card: _____.

MWPR does <u>not</u> require any person to apply for Medicaid or any other program/insurance to be eligible for the SFDP. Eligibility for the SFDP is solely based on income and family size.

Should you choose to disclose other insurance or payment options, and when permitted by the terms and conditions of our contract with your specific insurance company, the SFDP will be applied to your co-pay/deductible based on the allowable amount set forth by your insurance carrier. Balances due within 30 days from the billing statement date. Failure to comply with these financial requirements will place your account in default and it may be sent to a collection agency 30 days after default has occurred. Should it become necessary to send your account to a collection agency, you are responsible for all collection fees incurred in getting your account paid, including any attorney's fees.

HOUSEHOLD FAMILY MEMBERS AND INCOME: List any and all employment income for each family member in the household that are expected to file a tax return. Include all full-time, part-time, seasonal or temporary employment, tips, commission, etc. For self-employment, include the average monthly income. **Documentation of income will need to be provided before discount is approved. Please attach documentation to application.

Name of Household Member	Type/Source of Income	Total gross income per month?	Total gross income per year?

Total Number of Household Members: _____

Total Gross Household Income per Year: _____

FEDERAL POVERTY GUIDELINES: As stated, the SFDP is based on household size and income only. Upon acceptance of the application, the following table will be used to calculate the discounted fee rate for services rendered for each patient visit (i.e., the discount will be applied to each billable unit provided).

		ANNUAL HOUSEHOLD INCOME											
			Slide A		Slide B		Slide C		Slide D		Slide E		Slide F
			0% pay		20% pay		40% Pay		60% Pay		80% Pay		No Discount 100% Pay
			At of below 100%		125%		150%		175%		200%		Above 200%
FAMILY SIZE		1	0 - $12,760		$12,761-15,950		$15,951-19,140		$19,141-22,330		$22,331-25,520		$25,521+
		2	0 - $17,240		$17,241-21,550		$21,551-25,860		$25,861-30,170		$30,171-34,480		$34,481+
		3	0 - $21,720		$21,721-27,150		$27,151-32,580		$32,581-38,010		$38,011-43,440		$43,441+
		4	0 - $26,200		$26,201-32,750		$32,751-32580		$39,301-45,850		$45,851-52,400		$52,401+
		5	0 - $30,680		$30,681-38,350		$38,351-46,020		$46,021-53,690		$53,691-61,360		$61,361+
		6	0 - $35,160		$35,161-43,950		$43,951-52,740		$52,741-61,530		$61,531-70,320		$70,321+
		7	0 - $39,640		$39,641-49,550		$49,551-59,460		$59,461-69,370		$69,371-79,280		$79,281+
		8	0 - $44,120		$44,121-55,150		$55,151-66,180		$66,181-77,210		$77,211-88,240		$88,241+
		For each additional person, add:	$4,480		$5,600		$6,720		$7,840		$8,960		$8,960

By completing and submitting this application:

- I certify that the information provided on this application is true, complete, and accurate.
- I will provide documentation for all income as disclosed on the application.
- I understand that if the documentation is not received within 14-days of this dated application, the application will be re-dated to the date in which the information is submitted.
- I understand that the Sliding Fee Discount Program application covers balances incurred within 12 months after the approval date – so long as my income or household size does not change. I understand it is my responsibility to submit an updated application one year following each approval.
- I understand that I must report any and all changes to income and family size.
- I understand that remaining balances after the SFDP is applied that are more than 30-days past due could be turned over to a collection agency.
- I understand that providing information subsequently determined to be false will result in all discounts being revoked and the full balance of the account(s) restored and immediately due.

_____	_____	
Printed Client Name	Signed	Date
_____	_____	
Printed Parent of Guardian Name	Signed	Date
_____	_____	
Patient Account Representative (MWPR)	Signed	Date
_____	_____	
Participating Provider	Signed	Date