Sliding Fee Scale

Children's Therapy Place, Inc. accepts all patients regardless of their insurance or financial status. We offer the sliding-fee scale to all income eligible uninsured or under-insured clients based on annual household income for our mental health services. Income guidelines and acceptable verification for the sliding-fee scale is included.
If you have additional questions, feel free to contact our billing department at 208-323-8888.

How do I qualify?

To qualify for the Sliding Fee Scale you must show proof of gross annual income for all immediate family members living in your household. Gross income is all income from all sources before taxes. Applicants should provide a copy of either two consecutive pay stubs or the previous years income tax return or W-2 form.

Acceptable Income Verification:
-Recent Federal tax return
-IRS form, W2 or 1099
-Last 2 current paystubs

To begin the Sliding-fee fill out the application.

Children's Therapy Place, Inc. accepts Medicaid, and most major insurances. For clients who are uninsured or undersinsured, we offer a sliding fee scale. The sliding fee scales provides a variable cost on certain services to individuals that qualify.

Sliding Fee Scale program applications can be requested at any of our office locations. Once completed, the application and required income verification documents should be turned in to the office scheduler, who will submit it to the Administration Manager for review/approval within 24 hours of receipt. The Administration Manager will contact the family with the outcome of the application within 48 hours of receipt of the application, and also notify scheduler and billing department. The scheduler will then follow-up with the family for any scheduling needs, if they have not yet been scheduled.

Children's Therapy Place, Inc. does not discriminate on the basis of race, creed, color, ethnicity, national origin, religion, sex, sexual orientation, gender expression, age, height, weight, physical or mental ability, veteran status, military obligations, and marital status.

Sliding Fee Scale: Application Form

Patient Information			Today's Date: / /	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.
Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

Sliding Fee Scale:

A – 100% Discount
B – 50% Discount
C – 40% Discount
D – 30% Discount
E – 20%Discount
F – 10% Discount
G – 0%Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Children's Therapy Place, Inc. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Children's Therapy Place, Inc.. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Print):_____

Signature:_____

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