Sliding Fee Scale Discount Program:

Program Introduction for Families

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:

a. Paycheck stub (last two most recent)
b. Prior year W-2 Forms
c. Last Income Tax Return
d. Written statement from employer
e. Unemployment check stub
f. Social Security check stub
g. Self-Disclosure of income may also be used

To begin the Sliding-fee fill out the application.

Sliding Fee Scale program applications can be requested at any of our office locations. Once completed, the application and required income verification documents can be turned in to the front desk of any of our office locations or emailed to the Administration Manager. The Administration Manager will review and follow-up with the client and/or parent/legal guardian, with the outcome of the application within 48 hours of receipt of the application. Administration Manager will also notify the billing department and the scheduler of the outcome. 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, color, national origin, religion, sex, sexual orientation, gender identity, age, disability, veteran status, marital status, or the inability to pay.

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Sliding Fee Discount Program Application

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Date of Birth:	
Home Address:		City:	State:	Zip:

Parent/Guardian Information	
First Name:	Last Name:
Home/Cell Phone #: ( ) -	Email Address:

Household Size	List spouse and dependents under age 18		
Name	**Date of Birth**	**Name**	**Date of Birth**
Self	/ /	Dependent	/ /
Other	/ /	Dependent	/ /
Dependent	/ /	Dependent	/ /
Dependent	/ /	Dependent	/ /

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 complete this form every 12 months or if your financial situation changes.
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. Self-declaration of income may also be used. Your annual income and your family size will be used to calculate your discount.
See Sliding Fee Scale Calculation for additional details on discounts and rates.

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income			
Interest; dividends; royalties; income from rental properties, estates and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
TOTAL INCOME			

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. 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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OFFICE USE ONLY

Reviewed/Approved Date_____ Reviewed/Approved By_____
Approved Discount_____ Communication to family Complete Date_____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment identification or other		
Income: Prior year tax return, two most recent pay stubs, or other proof of income		