



**Sliding Fee Discount Application Form**

**Patient Information: Section 1**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Phone: \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

**Household Information: Section 2**

Please list everyone living in your home (yourself included). Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself). Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. DO NOT include non-cash assistance such as food stamps, housing allowance, or other government subsidies. To be considered a household member, the person must be listed below, Adults (except for your spouse) listed below with zero income must provide required documentation.

Name (First and Last)	Age	Source of Income or Name	Employer	Monthly Income

Please include income documentation for each ADULT listed above.

Total # of adults (18 years of age and older): \_\_\_\_\_

Total estimated gross annual income: \$ \_\_\_\_\_

Total # of children (under the age of 18): \_\_\_\_\_

Total # of household members: \_\_\_\_\_



**Sliding Fee Discount Application Form**

**Household Earnings Information**

*I do hereby swear and 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 discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Midwest Mental Health Clinic 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 Midwest Mental Health Clinic. I hereby acknowledge that I read the foregoing disclosure and understand it.*

*I consent to the release of any and all of my financial records including but not limited to: sliding fee scale application and supporting documentation, patient information, insurance information, and any other types of information contained within my electronic health records that may be deemed necessary to review by any auditor, for participating in any assistance programs including but not limited to sliding scale fee, grant-funded programs and/or pharmacy assistance programs for which I may be eligible.*

Date: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Witnessed by MMHC Staff: \_\_\_\_\_

Annual Income Thresholds by Sliding Fee discount: Pay Class and Percent Poverty						
Poverty Level*	100%*	125%	150%	175%	200%	>200%
Family Size	Minimum Fee (\$15)	20% Pay	40% Pay	60% Pay	80% Pay	100% Pay
1	\$13,590	\$16,988	\$20,385	\$23,783	\$27,180	\$27,316
2	\$18,310	\$22,888	\$27,465	\$32,043	\$36,620	\$36,803
3	\$23,030	\$28,888	\$34,545	\$40,303	\$46,060	\$46,290
4	\$27,750	\$34,688	\$41,625	\$48,563	\$55,500	\$55,778
5	\$32,470	\$40,588	\$48,705	\$56,823	\$64,940	\$65,265
6	\$37,190	\$46,488	\$55,785	\$65,083	\$74,380	\$74,752
7	\$41,910	\$52,388	\$62,865	\$73,343	\$83,820	\$84,239
8	\$46,630	\$58,288	\$69,945	\$81,603	\$93,260	\$93,726

\*Based on the 2022 Federal Poverty Guidelines (FPG) for the 48 contiguous states and the District of Columbia. Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines.

## FEE SCHEDULE

Psychiatric Diagnostic Evaluation (PMHNP): \$379  
MAT Initial Evaluation (PMHNP): \$379  
Therapy Initial Evaluation (LAC): \$250  
Therapy Session (LAC)-60 minutes : \$200  
Psychiatry Session (PMHNP) -60 minutes (PMHNP): \$300  
DUI Seminar (LAC): \$200  
Group Therapy (LAC)- 60 minutes: \$150