**REDISCOVER SLIDING FEE SCHEDULE**

ReDiscover provides services to all individuals regardless of ability to pay. At Intake, if it is determined that you do not have or are not eligible for Medicaid, Medicare, Commercial Insurance, Department of Mental Health General Revenue Funding, Jackson County Mental Health Levy Funding, or COMBAT Funding, you have the option to apply for a discounted self pay rate. This rate is based on Family Size and Income Level. Application is made by completing a simple one page form and attaching supporting documentation.

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| **Sliding Fee Income/Family Size Schedule** |
| Poverty Guideline\* | Less than 100% of Poverty | Up to 150% of Poverty | Up to 200% of Poverty | Up to 300% of Poverty | Up to 400% of Poverty | Above 400% of Poverty |
| Family Size | A | B | C | D | E | F |
| 1 | Below $12,880 annually | Up to $19,320 annually | Up to $25,760 annually  | Up to $38,640 annually  | Up to $51,520 annually  | Above $51,520 annually |
| 2 | Below $17,420 annually  | Up to $26,130 annually  | Up to $34,840 annually  | Up to $52,260 annually  | Up to $69,680 annually  | Above $69,680 annually |
| 3 | Below $21,960 annually  | Up to $32,940 annually  | Up to $43,920 annually  | Up to $65,880 annually  | Up to $87,840 annually  | Above $87,840 annually |
| 4 | Below $26,500 annually  | Up to $39,750 annually  | Up to $53,000 annually  | Up to $79,500 annually  | Up to $106,000 annually  | Above $106,000 annually |
| 5 | Below $31,040 annually  | Up to $46,560 annually  | Up to $62,080 annually  | Up to $93,120 annually  | Up to $124,160 annually  | Above $124,160 annually |
| 6 | Below $35,580 annually  | Up to $53,370 annually  | Up to $71,160 annually  | Up to $106,740 annually  | Up to $142,320 annually  | Above $142,320 annually |

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| **Discounted Fees** |
|   | A | B | C | D | E | F |
| Service | Nominal Fee |  |  |  |  | Full Fee> 400% FPL |
| Intake | No charge | No charge | No charge | No charge | No charge | 110.80 |
| Therapy |  10.00  |  20.00  |  30.00  |  40.00  | 60.00 | 110.80 |
| Case Management-F2F (daily rate) | No charge | No charge | No charge | No charge | 25.00 | 110.80 |
| Psych Evaluation |  25.00  |  50.00  |  75.00  |  100.00  | 150.00 | 220.00 |
| Med Check |  10.00  |  20.00  |  30.00  |  40.00  | 60.00 | 99.50 |
| **MH PHP/IOP Per Diem (incl Dr. Svcs)** | 20.00 |  25.00  |  25.00  |  50.00  | 75.00 | 450.00/400.00 |
| **SA Residential Per Diem (incl Dr. Svcs)** |  50.00  |  75.00  |  100.00  |  125.00  | 150.00 | 550.00 |
| **SA PHP/IOP Per Diem (incl Dr. Svcs)** |  20.00  |  25.00  |  25.00  |  50.00  | 75.00 | 450.00/400.00 |
| **Group Ed/Cnslng/Therapy (1 hour)** |  5.00  |  10.00  |  10.00  |  15.00  | 20.00 | 52.00 |
| **Methadone (Weekly)** | 75.00 | 100.00 | 100.00 | 100.00 | 125.00 | Full Fee as billed |
| **Suboxone (Weekly)** | 75.00 | 75.00 | 100.00 | 100.00 | 125.00 | Full Fee as billed |

**ReDiscover Sliding Fee Schedule Application**

**LOCATION:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**CLIENT ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Name of head of household | Place of employment |
| Home address | City | State | Zip |
| Phone | Social Security Number\* (Optional on NHSC SFS Applications) |

**Please list spouse and legal dependents under age 18**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Date of Birth | Name | Date of Birth |
| Self |  | Dependent |  |
| Spouse |  | Dependent |  |
| Dependent |  | Dependent |  |
| Dependent |  | Dependent |  |

**Annual Household Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Source | Self | Spouse | Dependents | Total |
| Gross wages, salaries, tips, etc. |  |  |  |  |
| Social Security, pension, annuity and veteran’s benefits |  |  |  |  |
| Alimony, child support, military family allotments |  |  |  |  |
| Income from business self employment and dependents |  |  |  |  |
| Rent, interest, dividend and other income |  |  |  |  |
| **TOTAL INCOME** |  |  |  |  |

**I certify that the family size and income information shown above is correct.**

**I acknowledge that I am responsible for notifying ReDiscover if my Income or Dependent status changes at anytime.**

**I understand that falsifying information on this form will result in loss of eligibility for the sliding fee schedule**

**I understand that this form must be resubmitted annually to maintain sliding fee status.**

**I accept responsibility for payment of the assigned fees associated with my services.**

**I understand it is my responsibility to inform ReDiscover of any change I may experience with Insurance, Medicare, or Medicaid coverage.**

|  |  |
| --- | --- |
| **Name (print):** | **Date:** |
| **Signature:** |  |

|  |  |
| --- | --- |
| **Staff Submitting Application:** | **Date Submitted:** |

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| **BILLING OFFICE USE ONLY** |
| Client Name: | Fee Schedule: (A,B,C,D or E) |
| Date: | Billing Manager Approval: |

|  |  |  |
| --- | --- | --- |
| **Verification Checklist-required before approval (attach)** | YES | NO |
| **Identification**: Driver’s license, birth certificate, employment ID, social security card |  |  |
| **Address:** Utility Bill, Bank Statement, Voter Registration Card |  |  |
| **Income:** Prior year Federal tax return, two consecutive pay stubs, Statement of Benefits, No-income affidavit |  |  |