SUMMIT
Community Counseling

FINANCIAL ASSISTANCE APPLICATION

SCC's Discount Fee Policy

The sliding fee scale is offered to individuals who have no insurance or do not the ability to pay the full cost of services. Individuals who feel they qualify for services may fill out this financial aid application. If they are found to qualify, the office manager will then set them up on the sliding fee scale. Discounts are offered based upon family/household size and annual income. A slide fee schedule is used to calculate the basic discount and is updated each year using the Federal Poverty Guidelines. Once approved, the discount will be honored for 3 months, after which the patient must reapply.

2014 Discounted/Sliding Fee Schedule

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty					
Poverty Level*	**100%**	**125%**	**150%**	**175%**	**>= 200%**
Family Size	$25 (nominal fee)	$35	$50	$70	$85
1	$11,670	$14,588	$17,505	$20,423	$23,340
2	$15.730	$19,663	$23,595	$27,528	$31,460
3	$19,790	$24,738	$29.685	$34,633	$39,580
4	$23,850	$29,813	$35,775	$41,738	$47,700
5	$27,910	$34,888	$41,865	$48,843	$55,820
6	$31,970	$39,963	$47,955	$55,948	$63,940
7	$36,030	$45,038	$54,045	$63,053	$72,060
8	$40,090	$50,113	$60,135	$70,158	$80,180
For each additional person, add:	$4,060	$5,075	$6,090	$7,105	$8,120

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Discount Application Process

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the business office before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

Services Covered and Excluded

It is the policy of Summit Community Counseling to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount.

This form must be completed every 3 months or sooner if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT		
STREET	CITY	STATE	ZIP	PHONE
HEALTH INSURANCE PLAN		SOCIAL SECURITY NUMBER:		

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE OF 18

	NAME	DATE OF BIRTH
SPOUSE		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		

ANNUAL HOUSEHOLD INCOME

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SOURCE	SELF	SPOUSE	OTHER	TOTAL
GROSS WAGES, SALARIES, TIPS, ETC.				$ 0.00
SOCIAL SECURITY, PENSION, ANNUITY, AND VETERAN'S BENEFITS				$ 0.00
ALIMONY, CHILD SUPPORT, MILITARY FAMILY ALLOTMENTS				$ 0.00
INCOME FROM BUSINESS, SELF EMPLOYMENT, AND DEPENDENTS				$ 0.00
RENT, INTEREST, DIVIDENT, AND OTHER INCOME				$ 0.00
TOTAL INCOME	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Note: *Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.*

I certify that the family size and income information show above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

NAME (PLEASE PRINT)	DATE:
SIGNATURE	

OFFICE USE ONLY

CLIENT NAME	DISCOUNT
APPROVED BY	DATE OF APPROVAL

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VERIFICATION CHECKLIST (ATTACH COPIES)	YES	NO
IDENTIFICATION/ADDRESS: DRIVER'S LICENSE, BIRTH CERTIFICATE, EMPLOYMENT ID, SOCIAL SECURITY CARD OR OTHER	☐	☐
INCOME: PRIOR YEAR TAX RETURN, THREE MOST RECENT PAY STUBS, OR OTHER	☐	☐
INSURANCE: INSURANCE CARD(S)	☐	☐
MEDICAID: APPLICATION MADE OR EVIDENCE OF REJECTION	☐	☐

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