Sliding Fee Discount Program

AmberCreek Counseling & Recovery Services has created a Sliding Fee Discount Program for our patients in need. It is very important to us that our program focuses on our patients and is there to improve access to care and assures that no patient will be denied services due to an inability to pay. Discounts are offered based upon household income and size. A sliding 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 six months, after which the patient must reapply.

Application Process

A completed application including the required documentation of 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 Included

Behavioral Health: Individual Psychotherapy	The discount is applied to all in-office services and Off-site services supplied by AmberCreek Counseling providers
Behavioral Health: Family & Couples Psychotherapy	The discount is applied to all in-office services and Off-site services supplied by AmberCreek Counseling providers
Behavioral Health: EMDR & Psychotherapy	The discount is applied to all in-office services supplied by AmberCreek Counseling providers

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Phone 775-284-9888• Fax 775-285-9091 Phone: 775-575-2144• Fax 775-575-2100

Sliding Fee Application

It is the policy of AmberCreek Counseling & Recovery Services, PLLC, Inc., to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services provided by AmberCreek Counseling & Recovery Services. If at any time additional services are required by facilities or providers outside of AmberCreek, we will refer you to places that also provide services regardless of your ability to pay. In the hope that your financial situation improves, discounts apply only to current, not future services. Please inquire at the front desk if you have questions.

Number of related persons living in your household: _____

Total household income: (complete one column)

Household Member	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children under the age of 18			
Total			

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

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

_____ _____

Name (Print) Signature/Date

Office Use Only

Patient Name _____ Discount_____

Date of Service _____ Approved by _____

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AmberCreek Counseling & Recovery Services, PLLC
Family Assistance Plan Application

Name of Head of Household	Place of Employment
Address City	State, Zip Code Phone Number
Health Insurance Plan	Social Security Number

Please list spouse and dependents under age 18

Name	Date of Birth		Name	Date of Birth
Spouse			Dependent	
Dependent			Dependent	
Dependent			Dependent	
Dependent			Dependent	
Dependent			Dependent	

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Annual Household Income

Source	Self	Spouse	Other	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				

Verification Checklist (attach copies)

	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other. ***NOTE***: Your inability to provide an ID will not affect your ability to receive services.		
Income: Prior year tax return, 3 most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application or evidence of rejection		

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Name (Print) Signature/Date

Office Use Only

Pay class approved: _____ Effective Date: _____

Approved by: _____ Expiration Date: _____

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