

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



Sliding Fee Application

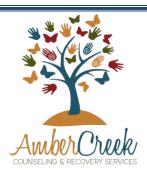
It is the policy of AmberCreek Counseling & Recovery Services, PLLC, Inc., to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members 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 rela	ted persons living in your h	ousehold:
	Total household income: (c	complete one column)

Household	Annual	Monthly	Bi-Weekly
Member			
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.



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 _________



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	



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 sh verification is required for appro	own above is correct and understand oval.
Name (Print)	Signature/Date
Pay class approved:	Office Use Only Effective Date:
Approved by:	Expiration Date: