Visionary Mental Health Services, LLC

Sliding Fee Application

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

I do hereby swear or 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 program and will subject me to penalties under Federal Laws which may include fines and imprisonment.

I further agree to inform Visionary Mental Health Services, LLC 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 Visionary Mental Health Services, LLC. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____
Name:_____

Signature: _____

NOTE: To comply with federal regulations, to give you a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every six months.

Your yearly income tax return, a copy of your W-2 forms, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Cost per session based on sliding fee scale:

A session is based on 53 minutes of therapeutic care at the billable rate of $200/session.

100% discount = $0/session

90% discount = $20/session

80% discount = $$40/session

70% discount = $60/session

60% discount = $80/session

50% discount = $100/session

40% discount = $120/session

30% discount = $140/session

20% discount = $160/session

10% discount = $180/session

0% discount = $200/session

Sliding Scale fee for therapeutic services:

	At or below 100%	120%	150%	180%	200%	Above 200%	
Family Size	0% Pay	20% Pay	50% Pay	80% Pay	90% Pay	100% Pay	
1	$15,060	$18,072	$22,590	$27,108	$30,120	$30,120+	
2	$20,440	$24,528	$30,660	$36,792	$40,880	$40,880+	
3	$25,820	$30,984	$38,730	$46,476	$51,640	$51,640+	
4	$31,200	$37,440	$46,800	$56,160	$62,400	$62,400+	
5	$36,580	$43,896	$54,870	$65,844	$73,160	$73,160+	
6	$41,960	$50,352	$67,136	$75,528	$83,920	$83,920+	
7	$47,340	$56,808	$71,010	$85,212	$94,680	$94,680+	
8	$52,720	$63,264	$79,080	$94,896	$105,440	$105,440+	
For each additional person add	$5,380	$6,456	$8,070	$9,684	$10,760	$10,760	

Based on the 2024 Federal Poverty Guidelines.