Sliding Fee Discount Application

Please complete the following information and return to office staff to determine if you are eligible for a discount. Applications are only applicable to the person seeking services, if other members of the family want services they will have to apply on a separate application. Please note that the approved discount rate goes into effect the date of approval. Please make sure to read everything to ensure you complete the form accurately and provide required documentation. Upon approval or denial, a detailed letter will be mailed out to the applicant with specific contract terms.

Office Staff Only
(Send directly to Billing Department)

Date received: _____

Initials of staff member: _____

2023 Poverty Guidelines
Maximum Annual Income Amount for each Sliding Fee Percentage (except for 0% discount)

Poverty Level	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%	200%	>200%
Family Size	Discount 100%	Discount 75%	Discount 70%	Discount 67%	Discount 65%	Discount 62%	Discount 50%	Discount 25%	Discount 20%	Discount 15%	Discount 10%	Discount 0%
1	$14,580	$18,225	$18,954	$19,391	$19,683	$20,120	$21,870	$25,515	$26,244	$26,973	$29,160	$29160+
2	$19,720	$24,650	$25,636	$26,228	$26,622	$27,214	$29,580	$34,510	$35,496	$26,482	$39,440	$39440+
3	$24,860	$31,075	$32,318	$33,064	$33,561	$34,307	$37,290	$43,505	$44,748	$45,991	$49,720	$49720+
4	$30,000	$37,500	$39,000	$39,900	$40,500	$41,400	$45,000	$52,500	$54,000	$55,500	$60,000	$60000+
5	$35,140	$43,925	$45,682	$46,736	$47,439	$48,493	$52,710	$61,495	$63,252	$65,009	$70,280	$70280+
6	$40,280	$50,350	$52,364	$53,572	$54,378	$55,586	$60,420	$70,490	$72,504	$74,518	$80,560	$80560+
7	$45,420	$56,775	$59,046	$60,409	$61,317	$62,680	$68,130	$79,485	$81,756	$84,027	$90,840	$90840+
8	$50,560	$63,200	$65,728	$67,245	$68,256	$69,773	$75,840	$88,480	$91,008	$93,536	$101,120	$101120+
For each additional person, add	$5,410	$6,425	$6,682	$6,836	$6,939	$7,093	$7,710	$8,995	$9,252	$9,509	$10,280	$10280+

*Based on 2023 Federal Poverty Guidelines (FPG) for the 48 contiguous states and the District of Columbia.

Name of Head of Household (HOH):			HOH Place of Employment:	
Name of person seeking services (applicant):				
Home Street Address:	City:	State:	Zip:	Contact Phone:
If client is a minor, responsible party:				

Please list head of household, spouse and dependents (when applicable)

Name (First, Last)	Date of Birth (MM/DD/YYYY)	Name (First, Last)	Date of Birth (MM/DD/YYYY)
HOH		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Sliding Fee Discount Application

Applicant Insurance Information	
Primary Insurance Carrier	**Secondary Insurance Carrier**
Insurance Company:	Insurance Company:
Phone (on back of card):	Phone (on back of card):
Claims Address:	Claims Address:
City/State/Zip:	City/State/Zip:
Policy Holder (PH):	Policy Holder (PH):
Relationship of PH to you:	Relationship of PH to you:
PH DOB:	PH DOB:
PH SS #:	PH SS #:
Policy ID:	Policy ID:
Group #:	Group #:

☐ **Applicant DOES NOT have insurance benefits**

Mark Requested Services: ☐ Individual Counseling ☐ Family Counseling

Annual Household Income

Source	HOH	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment and dependents				
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income.				
Interest, dividends, rents royalties, income from estates, trusts, education assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
Total Income:				

☐ **Household does not have ANY source of income**

Sliding Fee Discount Application

Required Documentation Checklist:

- ☐ Applicant/Responsible party's Driver's License or State issued ID
- ☐ Applicant/Responsible party's proof of address: utility bill, statement or letter with your/responsible party's name and address
- ☐ Proof of entire household income for the last 2 months *OR* prior year tax return if not currently working
- ☐ Copy of applicant's health insurance card

I _____ (print name) certify that the family size and income information shown above is correct. I understand that I will need to reapply every 6 months to maintain my discount. If my family size and/or income information changes before that 6-month period is up, I understand that I will need to fill out a new application. I also certify that I have received the information brochure regarding the sliding fee program at Tueller Counseling Services, Inc.

I also understand that any approved discount will not go into effect until this application has been approved. The full amount will be owed on any services received before the approval date. Tueller Counseling Services is required to contact any applicant's insurance company regarding the sliding fee program. Prices will vary depending on your approved discount and the insurance company policies. Specific information will be provided to the applicant in the approval letter. If you are unsatisfied with the insured discount offered, you may opt to self-pay (full rate) at that time.

_____ _____

Signature Date

Please note: If the application is not complete or incorrect, Tueller Counseling will attempt to contact the applicant. If no response is received within 10 business days, the application will be void and a new application will be required with updated documentation.

Office Use Only

Date Received by Billing: _____

Patient Name: _____

Approved Discount: _____ Intake: _____ Individual Session: _____ Family Session: _____

Approved by Admin Team on: _____

Attempts to collect information:

_____

_____

_____

_____