Sliding Scale Fee Qualification Form

It is the policy of Astra Behavioral Health (ABH) to make available discount services to those in need. This program is designed to provide free or discounted quality behavioral health services to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). The objective of this program is to assist to take the stress out of paying your medical bills. Astra Behavioral Health will base program eligibility on a person's ability to pay and will not discriminate based on age, gender, race, sexual orientation, creed, religion, disability, or national origin.

ELIGIBILITY:

The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility. Discounts are offered based on family size and annual income. Please complete the following form and return to our office to determine if you or members of your family are eligible for a discount.

a. **Family** is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

b. **Income** includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.* If the applicant does not have any income to report, a notarized letter written by someone outside of the household stating that the applicant does not have any income must be submitted.

Sliding Scale Application and all required documents will be submitted to the Financial Counselor for processing. The Financial Counselor will notify the patient and the office manager of the patients' responsibility and note in the patient's chart.

Note: The discount will apply to all basic services received at our offices, but not those services that are provided from outside entities such as prescriptions and/or labs. Case Management services and TMS services are not included in the sliding discount program.

SLIDING FEE SCHEDULE

·, Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty

Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size				**Charge**		
	Nominal Fee ($15)	**20% pay**	**40% pay**	**60% pay**	**80% pay**	**100% pay**
1	$0-$12,880	$12,881- $16,100	$16,101-$19,320	$19,321- $22,540	$22,541- 25,760	$25,761+
2	$0-$17,420	$17,421- $21,775	$21,776- $26,130	$26,131- $30,485	$30,486-$34,840	$34,841+
3	$0-$21,960	$21,961- $27,450	$27,451- $32,940	$32,941- $38,430	$38,431- $43,920	$43,921+
4	$0-$26,500	$26,501- $33,125	$33,126- $39,750	$39,751- $46,375	$46,376- $53,000	$53,001+
5	[1]$0-$31,040	$31,041- $38,800	$38,801- $46,560	$46,561- $54,320	$54,321- $62,080	$62,081+
6	$0-$35,580	$35,581- $44,475	$44,476- $53,370	$53,371- $62,265	$62,266- $71,160	$71,161+
7	$0-$40,120	$40,121- $50,150	$50,151- $60,180	$60,181- $70,210	$70,211- $80,240	$80,241+
8	$0-$44,660	$44,661- $55,825	$55,826- $66,990	$66,991- $78,155	$78,156- $89,320	$89,321+
Addt'l	**$4,540**	**$5,675**	**$6,810**	**$7,945**	**$9,080**	**$9,080**

*Based on The US DEPARTMENT OF HEALTH AND HUMAN SERVICES 2021 **Federal Poverty Guidelines** for the 48 contiguous states and the District of Columbia.

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PATIENT INFORMATION			Date: / /
FIRST NAME:	LAST NAME:	DOB:	SSN:
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	EMAIL:	
DO YOU HAVE HEALTH INSURANCE? (Circle One) YES NO		MARITAL STATUS? (Circle One) SINGLE MARRIED	

NOTE: To comply with federal regulations, to give you a discount on our behavioral health 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 year or whenever asked by our office.

HOUSEHOLD SIZE

NAME	DATE OF BIRTH	SSN
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

HOUSEHOLD GROSS INCOME (Monthly)

PATIENT'S EMPLOYER (IF MINOR, MOM'S INFO):	PHONE:
SPOUSE'S EMPLOYER (IF MINOR, DAD'S INFO):	PHONE:

Other Income	Patient	Spouse	Children	Legal Guardian	Subtotal
SALARY/WAGES/TIPS	$	$	$	$	$
SELF EMPLOYED/BUSINESS	$	$	$	$	$
SSI/DISABILITY	$	$	$	$	$
CHILD SUPPORT/ALIMONY	$	$	$	$	$
RETIREMENT/PENSION	$	$	$	$	$
K-TAP	$	$	$	$	$
UNEMPLOYMENT	$	$	$	$	$
PUBLIC ASSISTANCE	$	$	$	$	$
WORKER'S COMP	$	$	$	$	$
OTHER INCOME	$	$	$	$	$
IF NO INCOME, HOW DO YOU PAY YOUR BILLS ?					

PROPERTY/ASSETS

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN REAL ESTATE OR OTHER PROPERTY? YES NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION

1 . VALUE: $_____ AMOUNT OWED: $_____ MONTHLY INSTALLMENT: $_____

2. VALUE: $_____ AMOUNT OWED: $_____ MONTHLY INSTALLMENT: $_____

DO YOU LIVE IN A RENTAL PROPERTY? YES N0

MONTHLY RENT: $_____

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THIS CERTIFIES THAT I REQUEST TO BE CONSIDERED FOR FINANCIAL ASSISTANCE AT ASTRA BH

I, _____ certify that the family size and income information shown above is correct and true to the best of my knowledge. I further certify that I do not have health insurance (or certify that I will not/cannot utilize any health insurance for services rendered by the ASTRA Behavioral Health, LLC and/or due to my current financial situation, I cannot afford the full fee rate according to the fee schedule. I, therefore, request that my fee be adjusted. I agree to notify ASTRA Behavioral Health, LLC of any substantive changes in my financial situation within 15 days of the change. I further acknowledge that ASTRA Behavioral Health, LLC will periodically review my financial status with me every 4-10 consecutive weeks, to reassess eligibility and provide any additional documents asked by ASTRA BH to determine my financial eligibility.

X _____ DATE:_____

RESPONSIBLE PARTY

Supporting Documents

- ☐ Federal Tax Return (Form 1040) – Most recent
- ☐ 3 Months Paycheck Stubs
- ☐ 3 Months Bank Statement
- ☐ Proof of SSI
- ☐ Proof of Pension
- ☐ Proof of Unemployment Insurnance

Please return the form and above-mentioned documents at the following address

ASTRA Behavioral Health, LLC
2000 Ring Road
Elizabethtown, KY 42701

Financial Assistance Phone: (270) 506-2730, EXT: 803 (Billing Office)

For Office Use only:

Approved Discount:	**%**	**Discounted Fee:**
Approved BY:	**Date:**	**Date of next review:**