**A New Tomorrow**

**Behavioral Health Services**

**SLIDING FEE SCALE APPLICATION**

**26 Wesmark Ct., Sumter, S.C. 29150**

**Phone: (803) 883-4981 Fax: (803) 883-5492**

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At A NEW TOMORROW, we make it a policy to provide essential behavioral health services regardless of a client's ability to pay. We offer discounts based on income and family size.

Please fill out the form below and return it to the front desk to determine if you or your family members are eligible for a discount. You must complete this form every 12 months or if your financial situation changes.

**NAME:**

**ADDRESS:**

**TELEPHONE:**

**Please list all household members, including those under the age of 18.**

|  |  |  |
| --- | --- | --- |
|  |  **NAME** | **DATE OF BIRTH** |
| **SELF** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |

**I HAVE provided the following sources of income verification with the application (select one)**

|  |  |  |  |
| --- | --- | --- | --- |
| **SOURCE OF INCOME** | **OWN** | **OTHER** | **TOTAL** |
|  **The last two paycheck stubs for each adult working in the household.** |  |  |  |
| **Unemployment benefit letter.** |  |  |  |
| **Social Security benefit letter showing your monthly payment.** |  |  |  |
| **Last (current year) Federal tax returns, quarterly tax statements if self-employed.** |  |  |  |
| **Verification of Workers Compensation insurance Benefits** |  |  |  |
| **Payment made from trusts or estate verification** |  |  |  |
| **Documentations of child support (divorce papers, letter from recovery services)** |  |  |  |
| **Copy of pension/retirement benefits** |  |  |  |
| **Documentation of State Support** |  |  |  |
| **1040 or W2 statement due to loss of employment** |  |  |  |
| **I HAVE NOT SUBMITTED ANY SOURCES OF INCOME VERIFICATION AND UNDERSTAND THAT I HAVE (5) FIVE BUSINESS DAY TO BRING IN INCOME VERIFICATION OR I WILL BE BILLED FOR THE FULL COST OF SERVICES RENDERED.** |  |  |  |

I understand if I qualify for the Sliding Fee Discount Plan, an office fee may be charged for each visit depending on the service rendered. I understand I must apply for the Sliding Fee Discount Plan every 12 months. I understand that I must list all family members and wage earners in my family and provide income verification to be eligible for the Sliding Fee Discount Plan. I give A New Tomorrow BHS staff permission to contact my employer or any other appropriate source to verify. I authorize A New Tomorrow BHS to bill my insurance carrier for services rendered by our providers. I also authorize A New Tomorrow to release all or part of my/patient’s record to any person or organization I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of medical insurance benefits be paid to A New Tomorrow BHS.

**I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney’s fees**.

I understand that if any of this information has been falsified to fraudulently receive services that my participation will be revoked, and will be responsible for 100% of the unusual and customary charges of A New Tomorrow BHS. I will notify A New Tomorrow BHS of any changes in my health status or any of the above information.

**I certify that the information shown above is correct:**

## NAME (Print):

**DATE:**

## SIGNATURE:

**OFFICE USE ONLY**

# **Patient Name:**

# **Approved Discount:**

 **Approved By:**

# **Date of Approval:**

|  |  |  |
| --- | --- | --- |
|  **CHECKLIST** | **YES** | **NO** |
| **Identification / Address: Driver's License, utility bill, employment ID or other** |  |  |
| **Income: Prior year's tax return, three (3) most recent pay stubs, or other** |  |  |