Plains Area Mental Health
Fee Reduction Program

What is the Fee Reduction?

A fee reduction is the cost you pay, that is determined by your income and family size. For example, if you have very low income you will be asked to pay less for a service than someone who has more income

Can anyone apply for the Fee Reduction program?
Yes. We encourage everyone to apply for the Fee Reduction program

Can I apply for the Fee Reduction program if I have insurance with high deductible or uncover services?
Yes. Insured patients may also be eligible for discounted services for uncovered insurance services based on income and family size.

What do I need to bring to Plains Area Mental Health to apply for the Fee Reduction program?

- *Your most recent income tax for every working adult in your household*
- *One month of you most recent pay stubs for every working adult in the household*
- *Names, birthdates and social security numbers for each person in your household*
- *Please review the checklist for other kinds of proof of income*

How much time do I have to complete and return my Fee Reduction application?
All documentation, including the application, needs to be received by PAMHC within One (1) Month of your visit.

How long is the Fee Reduction application valid for if approved?
A fee reduction application is valid for 6 months, if still receiving services after 6 months of initial financial assistance application, a new application will need to be submitted.

Are there Services that are NOT eligible for Fee Reduction?
Yes, Psychological Evaluation/Testing Services and DOT evaluations are not eligible for fee reduction.

Please contact your local PAMHC office if you have further questions about our Fee Reduction/Scholarship Application.

Fee Reduction Application Check List

Please bring one of the following with your completed Application:

- ☐ Current Federal Income Tax Form (1040 or 1040EZ)
- ☐ Pension Payments, Veteran's Benefits
- ☐ Most recent one month of pay stubs
- ☐ Employer statements for cash wages (must include employer name, address, phone number, and signature)
- ☐ Print out report from office issuing payment (SS, SSI, SSD, unemployment, VA, etc)

Sliding Fee Scale Application
Plains Area Mental Health

Application Introduced By: _____ ***Date:*** _____ ***Due Date:*** _____

Client's Full Name_____Date of Birth_____
Address_____Apt/Lot # __Home Phone #_____Cell_____
City_____State_____Zip Code_____

Have you or any of your household members applied for Medicaid (Title XIX) Yes □ No □
If yes, When /Who:_____

Please list all household members, including you, below:

First & Last Name	Date of Birth	Social Security #	Income source	Relationship

You are required to provide proof of income for all working adults in household in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax Form (1040 or 1040EZ)
- Pension Payments, Veteran's Benefits
- Most recent one month of pay stubs
- Employer statements for cash wages (must include employer name, address, phone number, and signature)
- Print out report from office issuing payment (SS, SSI, SSD, unemployment, VA, etc)

I declare that my household's financial status is as listed above, and I am responsible for these household member bills. I realize that Plains Area Mental Health is utilizing federal tax dollars to assist me in receiving health care. I understand that giving false information regarding my household income is considered fraud against the United States government.

Guarantor/Applicant Signature_____ Date_____

Guarantor/Applicant Printed Name _____

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TO BE COMPLETED BY THERAPIST

For each client in this account, please describe the following:
Date of first appointment _____
Diagnosis: _____
Primary Objective: _____
Current Risk Factor: _____
_____
Motivation of Client: _____
Frequency of visits: _____
Length of visits: _____
Number of additional visits requested: _____

Any legal problems? _____
Court problems? _____

Therapist Signature: _____ Date: _____

TO BE COMPLETED BY ADMINISTRATIVE SUPPPORT STAFF

Office: _____

CPC Completed: Yes No Approved: Yes N

Current Bill? Yes No Amount $_____

Amount of payment _____ per week per month (circle one)

Is insurance or will insurance will pay? Yes No Amount $_____

ADM Support Signature: _____ Date: _____
Yearly GROSS family income: _____ # Persons in household _____ = _____%PGL

DETERMINATION OF SCHOLARSHIP

_____ Fee is to remain the same

_____ Fee rate is to be adjusted to _____% Effective Date: _____ Expiration Date: _____

Authorizing Signature: _____ Date: _____

When form is completed:
_____ Original scanned into Chart
_____ Fee Reduction added as insurance and liability including start and end date by Office Manager
_____ Guarantor notified by staff Date: _____ Staff initials: ____

FEE REDUCTION

SLIDING FEE SCALE

PGL	Co Pay % (percentage of a full charge)
151% to 159%	5%
160% to 169%	10%
170% to 179%	20%
180% to 189%	30%
190% to 199%	40%
200% to 209%	50%
210% to 219%	60%
220% to 229%	70%
230% to 239%	80%
240% to 249%	90%
250% and more	100%

Please contact Office location to receive more information on a Request for Scholarship.