Sliding Fee Discount Application

It is the policy of Siouxland Mental Health Center to provide behavioral health services regardless of the patient's inability to pay. Discounts are offered based on household size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside entities, including reference laboratory testing, drugs and other such services. This form must be completed every 12 months or if your financial situation changes.

Siouxland Mental Health Center is a Federally Qualified Health Center. We are able to offer a discount on some services based on a household's income and size. Sliding fee calculations are determined by using Federal Income Tax forms, W-2's or last two consecutive pay stubs. SMHC then uses the Sliding Fee table to determine eligibility.

Your household discount will be assessed on an annual basis.

PLEASE NOTE: Patient may be responsible for the payment of some procedures, labs and medications.

If you have any questions please contact the SMHC Billing Department at 712-252-3871.

Siouxland Mental Health Center (SMHC) is a nonprofit community mental health center that provides a comprehensive range of mental health services for the evaluation and treatment of people of all ages experiencing mental illness, individual or family emotional distress, and overwhelmingly stressful circumstances.

Siouxland Mental Health Center serves all individuals within Woodbury County for the treatment of mental illness.

Siouxland Mental Health Center
625 Court Street
Sioux City, IA 51102
www.siouxlandmentalhealth.com
712-252-3871

Sliding Fee Discount Program

"Making a difference in the community, by making a difference in people's lives"

712-252-3871

Siouxland Mental Health Center Sliding Fee Application

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed, signed & dated, and submitted to the receptionist, along with proof of income (see listing on back side for acceptable forms of income).

Head of Household: Last________________ First ________________ Phone ____________
Mailing Address: ____________________City ____________ State ______ Zip ______

Have you or any of your household members applied for Medicaid (Title XIX)? Yes ☐ No ☐

Sources of Income: All members living in the household. "Household" is considered all persons living with you at the same address. If living situation is temporary, please advise Siouxland Mental Health staff of your situation.

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment and dependents				
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, education assistance, alimony, child support, assistance from outside the household and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

HOUSEHOLD SIZE: List all household members by NAME AND DATE OF BIRTH, include yourself:

NAME	DATE of BIRTH	NAME	DATE of BIRTH

I certify that the family size and income information shown above is correct.

Signature ______________________ Date ____________

Office Use Only

To be completed by SMHC Staff

☐ Proof of income verified ☐ Patient refused to complete ☐ Patient does not qualify for sliding fee

Has patient or any household members applied for Medicaid/Medicare/other assistance? ☐ Yes ☐ No
Notes: ________________________________

Sliding Fee Scale Level Approved: A B C D E Fee Amount: $__________

Reviewed for past dates of service for adjustments: ☐ Yes ☐ N/A By: ____________

Identification/Address: Driver's license, utility bill, employment ID or other? ☐ Yes ☐ No
Income: Prior year tax return, three most recent pay stubs, or other? ☐ Yes ☐ No
Insurance: Insurance Cards? ☐ Yes ☐ No

______________________ ____________
Verified By Date