Sliding Fee Discount Application

It is the policy of Siouxland Mental Health Center to provide behavioral health services regardless of the patient's ability 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 therapy and psychiatric 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 Community Mental 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 at least an annual basis or if your financial situation changes.

PLEASE NOTE: Patients 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 non-profit 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 for the treatment of mental illness.

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

SIOUXLAND
MENTAL HEALTH CENTER

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 front desk, along with proof of income (see listing on back side for acceptable forms of income).

Last Name _____ First Name _____ Phone _____

Address: _____City _____ State _____ Zip _____

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

Optional: 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