Crossroads
Mental Health Services, PLLC
812 W. 8th Street, Suite 6A ♦Plainview, Texas 79072 ♦www.crossroadsmentalhealthservices.com

SLIDING FEE SCALE INFORMATION AND AGREEMENT FORM

The sliding fee scale allows Crossroads Mental Health Services, PLLC to reduce or "slide" the fees for therapy services. Eligibility is based on family income and family size. Your fee will always be at least $40 for therapy services. This minimum amount is due at the time of your appointment, as well as payment for any other unpaid balances.

To apply for the sliding fee, please provide any of the following documentation of income for all household members:

- Tax Return
- Last month's pay stubs
- Unemployment benefit statement
- Copy of Social Security checks

To comply with federal regulations, in order to offer the sliding fees for therapy services, it is necessary that you provide personal information. This information will be kept on file and in strict confidence. You must verify your income at least annually with any of the above listed types of documentation. Initials _____

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee scale program and will subject me to penalties under Federal Laws, which may include fines and imprisonment. I further agree to inform Crossroads Mental Health Services, PLLC if there is a significant change in my income. If acceptance to the sliding fee scale program is obtained under this application, I will comply with all rules and regulations of Crossroads Mental Health Services, PLLC. I hereby acknowledge that I read the foregoing disclosure and understand it.

_____ _____

Printed Name Date

_____

Signature

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SLIDING FEE SCALE ELIGIBILITY FORM

PATIENT INFORMATION		**TODAY'S DATE: / /**	
First Name:	Middle:	Last:	
Home Address		City, State, Zip	
Mailing Address (If different from above)		City, State, Zip	
Home Phone: ( )	Cell Phone: ( )	Date of Birth	SSN
Martial Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Widowed		Do you have insurance? ☐ Yes ☐ No	

Household Income

Individual/Spouse	Amount	Frequency	Employer
You	$	☐ Weekly ☐ Monthly ☐ Yearly	
Spouse	$	Weekly ☐ Monthly ☐ Yearly	
Child(ren)	$	Weekly ☐ Monthly ☐ Yearly	
Social Security	$	Weekly ☐ Monthly ☐ Yearly	
Other	$	Weekly ☐ Monthly ☐ Yearly	
TOTAL	$	Weekly ☐ Monthly ☐ Yearly	

Determination: Total Income/Poverty Guideline for Household Size = Percentage of Poverty Guideline

Determination: _____ / _____ = _____%

Client's Percentage of Poverty Guideline: _____ Slide Level Eligibility: _____

Federal Poverty Level	<100% FPL	101-133% FPL	134-166% FPL	167-199% FPL	>200% FPL
Slide Level	**A**	**B**	**C**	**D**	**E**
Initial Consultation Patient Responsibility	$40.00	$63.75	$87.50	$111.25	$135 (100% of charges)
Subsequent Therapy Sessions Patient Responsibility	$40.00	$57.50	$75.00	$92.50	$110 (100% of charges)

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2018 FEDERAL POVERTY GUIDELINES

2018 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,320 for each additional person.	
1	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$38,060
8	$42,380