myAvatar ID: _____

NorthCare Sliding Fee Discount Program

NorthCare offers a sliding fee scale. This means we can reduce your charges based upon your household size and income. Insurance co-payments are excluded from sliding fee discounts. Once approved for sliding fee, your coverage is valid for one year. You must re-certify every year to maintain your coverage.

Sliding Fee Discount Income Verification Guidelines
Please complete Sliding Fee Discount Application entirely, sign application and return application and income information to the front desk. Discounts are based on family size and income only.

Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. NorthCare will also accept non-related household members when calculating family size.

Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

You must provide at least one of the following:

- Prior year W-2.
- Two most recent pay stubs.
- Letter from employer that must include employers name, address and phone number.
- Form 4506-T (if W-2 not filed).
- Form 1040 or 1040A.
- Social Security letter or bank statement for fixed incomes such as social security, disability, pension, etc.
- Snap benefits letter from food stamp office.
- Unemployment compensation paycheck stubs.
- Letter of reference from any 501(c) (3) non-profit organizations such as homeless shelters or churches.
- Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business.

Return application and proof of income to the front desk before or at the next visit. Discount will start on the day the completed application and proof of income is returned and approved. Discounts are good one year unless financial situation changes significantly.

We will contact you in writing if you are denied for any reason.

myAvatar ID: _____

NorthCare Sliding Fee Discount Program Application

Patient Information		**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:
Home Address:		City:	State: Zip:
Mailing Address:		City:	State: Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -	
Date of Birth: / /			

Household Size		
Name	**Date of Birth**	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

NOTE: To comply with federal regulations, in order to give you a discount on our services, it is necessary for us to ask some personal questions.
Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Please bring yearly income tax return, copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive as proof of family income.
Only the family size and annual income will be used to determine your eligibility and calculate your discount.

Household Income (gross wages, salaries, tips, income from business and self-employment, unemployment)

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security/Supplement Social Security					
Workers Compensation					
Retirement Pension					
Rental Properties, Estates, Trusts					
Child Support, Alimony					
Interest Income/Dividends/Royalties					
Other/Miscellaneous					
				TOTAL	**$**

Sliding Fee Scale:

A – 0%-134%

B – 135%- 200%FPL

C – 201%-299% FPL

D – 300%+ FPL

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By signing my name below, I attest 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 discount program. I further agree to inform NorthCare if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of NorthCare. I hereby acknowledge that I read the foregoing disclosure and understand it.

Consumer Printed Name: _____

Consumer Signature: _____ Date: _____

STAFF USE ONLY

NC Staff: _____ Date: _____ S/S Termination Date _____

Based on your monthly income of $_____ and a family size of _____ consumer qualifies for SS level _____ (12 months)

myAvatar ID: _____

Sliding Fee Scale Effective 7/1/2025

Persons in Household	0%-134% (A)	135%-200% (B)	201%-299% (C)	300% + (D)
1	$0 - $21,127.49	$21,127.50 - $31,300	$31,301 - $46,949	$46,950
2	$0 - $28,552.49	$28,552.50 - $42,300	$42,301 - $63,449	$63,450
3	$0 - $35,977.49	$35,977.50 - $53,300	$53,301 - $79,949	$79,950
4	$0 - $43,402.49	$43,402.50 - $64,300	$64,301 - $96,449	$96,450
5	$0 - $50,827.49	$50,827.50 - $75,300	$75,301 - $112,949	$112,950
6	$0 - $58,252.49	$58,252.50 - $86,300	$86,301 - $129,449	$129,450
7	$0 - $65,677.49	$65,677.50 - $97,300	$97,301 - $145,949	$145,950
8	$0 - $73,102.49	$73,102.50 - $108,300	$108,301 - $162,449	$162,450
9	$0 - $80,527.49	$80,527.50 - $119,300	$119,301 - $178,949	$178,950

	0%-134% (A)	135%-200% (B)	201%-300% (C)	301%-400% (D)
Competency Evaluation Assessment	$0.00	$0.00	$67.54	$135.08
Intake Admission Assessment	$0.00	$0.00	$87.50	$175.00
Treatment Plan-Initial	$0.00	$0.00	$50.00	$100.00
Treatment Plan-Review	$0.00	$0.00	$37.50	$75.00
Individual Therapy	$0.00	$0.00	$48.00	$96.00
Group Therapy	$0.00	$0.00	$24.00	$48.00
Family Therapy w Client	$0.00	$0.00	$48.00	$96.00
Family Therapy w/o Client	$0.00	$0.00	$48.00	$96.00
Individual Rehab	$0.00	$0.00	$30.00	$60.00
Group Rehab	$0.00	$0.00	$8.00	$16.00
Case Management BHCM I	$0.00	$0.00	$22.50	$45.00
Case Management, BHCM II	$0.00	$0.00	$22.50	$45.00
Case Management, LBHP	$0.00	$0.00	$22.50	$45.00
Peer Recovery Support - Individual	$0.00	$0.00	$19.50	$39.00
Peer Recovery Support - Group	$0.00	$0.00	$3.00	$6.00
Wellness Group	$0.00	$0.00	$9.00	$18.00
Wraparound(Targeted), BHCM II, CADC/SOC	$0.00	$0.00	$32.50	$65.00
Transitional Case Management, BHCM I	$0.00	$0.00	$15.00	$30.00
Transitional Case Management, BHCM II	$0.00	$0.00	$27.50	$55.00
Transitional Case Management, LBHP	$0.00	$0.00	$37.50	$75.00
Travel	$0.00	$0.00	$32.50	$65.00
E/M NEW	$0.00	$0.00	$75.00	$150.00
E/M Established	$0.00	$0.00	$71.25	$95.00
Medication Training and Support/Nursing Assessment	$0.00	$0.00	$47.50	$95.00
Family Training and Support	$0.00	$0.00	$19.50	$39.00
Screening & Referral	$0.00	$0.00	$10.00	$20.00