

Community Counseling Center
Sliding Fee Scale

CLIENT'S NAME: _____

DATE: _____

CLIENT ID: _____

Reduction of your fees according to this scale is contingent upon verifying information. Such documentation should be provided at the intake session at which your share of costs is determined. If this documentation cannot be provided at intake, then a case management session must be scheduled for this purpose before any recommended treatment may begin. Indigent clients, including those who are non-citizens and/or homeless may not be able to provide any of the documentation requested below. If you can provide a letter from any other agency, local service provider verifying your status, you will be assessed fees based on \$0 income for the provision of services. Should a letter be unavailable, the program's no documentation policy may be used. To view the Federal Poverty Guidelines published by the Department of Health and Human Services, visit: <https://aspe.hhs.gov/poverty-guidelines>

TOTAL ANNUAL INCOME: Identify all income received by the client and others residing in the same household during the past twelve months (gross money, wages, & salaries before any deductions). Write calculations on back.

NUMBER IN HOUSEHOLD: Enter number including client. List all member of the household and their annual income on the back of this form.

Fee Determination Scale - Based on Federal Poverty Guidelines published by HHS.									
Number of people in the household	Annual Household Income								
	100%	150%		200%		250%		251% +	
		From	To	From	To	From	To	From	To
1	\$15,960	-	\$23,940	\$23,941	\$31,920	\$31,921	\$39,900	\$39,901	+
2	\$21,640	-	\$32,460	\$32,461	\$43,280	\$43,281	\$54,100	\$54,101	+
3	\$27,320	-	\$40,980	\$40,981	\$54,640	\$54,641	\$68,300	\$68,301	+
4	\$33,000	-	\$49,500	\$49,501	\$66,000	\$66,001	\$82,500	\$82,501	+
5	\$38,680	-	\$58,020	\$58,021	\$77,360	\$77,361	\$96,700	\$96,701	+
6	\$44,360	-	\$66,540	\$66,541	\$88,720	\$88,721	\$110,900	\$110,901	+
7	\$50,040	-	\$75,060	\$75,061	\$100,080	\$100,081	\$125,100	\$125,101	+
8	\$55,720	-	\$83,580	\$83,581	\$111,440	\$111,441	\$139,300	\$139,301	+

For families/households with more than 8 persons, add \$5,500.00 for each additional person.

	For AWARDS	25%	50%	75%	100%
Screening	\$	10.00	\$ 20.00	\$ 30.00	\$ 40.00
Evaluation	\$	50.00	\$ 100.00	\$ 150.00	\$ 200.00
Individual	\$	40.00	\$ 80.00	\$ 120.00	\$ 160.00
Group	\$	15.00	\$ 30.00	\$ 45.00	\$ 60.00
IOP Day Rate	\$	48.00	\$ 96.00	\$ 144.00	\$ 192.00

If you are a non-emancipated minor under 18 years of age, your parent or legal guardian must sign the application. If you are a dependent adult under a conservatorship of estate, your conservator must sign the application.

By signing below, I acknowledge that I have received a copy of this information, and I understand that I will be responsible for my treatment costs. The costs of my treatment will be based on the number and types of services offered me. I can review my costs for treatment at any time. I understand that if my insurance/financial situation changes during treatment, I need to inform CCC staff and revised sliding fee calculations will be made and will be effective for services provided after the date the new scale is signed. I further acknowledge that all information provided by me is

CLIENT/GUARDIAN _____ **DATE:** _____

SIGNATURE:

STAFF SIGNATURE:

Household Members:

Name	Annual Income	Age	Relationship to Client
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Total Household Income:

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List Income Backup Documentation and Calculations:

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