ASPIRE BEHAVIORAL CONNECTIONS

SLIDING FEE SCALE ELIBILITY

# Aspire Provides Services Regardless of Patient's Ability to Pay

It is the policy of ASPIRE BEHAVIORAL CONNECTIONS, LLC to provide essential services regardless of the patient's ability to pay. Sliding Fee Scale discounts are offered based upon family income and size, which may adjust the cost of your office visits and medications. Persons who may contribute to your family/household size may include yourself, spouse, domestic partner, children under 18; and parents, grandparents and adult children.

The Sliding Fee Scale discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting provider, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. To remain eligible, this form must be updated regularly.

Please complete the Discount/Sliding Fee application and the Family Assistance Plan application and return to Aspire's Intake/Registration Desk to determine if you or members of your family are eligible for a discount.

In addition to the application, please provide the following:

- A valid ID for all family members applying for the discount

  **Examples include, but are not limited to:**

  - Driver's License
  - State ID card
  - Photo ID from Casa de Maryland
  - Official School Enrollment Letter
  - Consulate Cards
  - Passport
  - The most recent federal tax filing form (if applicable)

**And ONE of the following:**

- Last months' worth pay stubs;
- Award or benefit letter from the government;
- Letter from employer on company letterhead or employer statement stating wages; **OR**
- Two unemployment stubs

All forms of income include earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance (e.g. Temporary Cash Assistance), veterans' payments, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, employer statements and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies) do not count*.

If you do not have these items, call us at (410) 292-0130 for further assistance.

ASPIRE BEHAVIORAL CONNECTIONS

# 2022 FEDERAL POVERTY GUIDELINES

## 48 CONTIGUOUS STATES AND D.C.

| Household Size | 100% | 150% | 200% | 250% | 300% |
|---|---|---|---|---|---|
| 1 | $ 13,590.00 | $ 20,385.00 | $ 27,180.00 | $ 33,975.00 | $ 40,770.00 |
| 2 | $ 18,310.00 | $ 27,465.00 | $ 36,620.00 | $ 45,775.00 | $ 54,930.00 |
| 3 | $ 23,030.00 | $ 34,545.00 | $ 46,060.00 | $ 57,575.00 | $ 69,090.00 |
| 4 | $ 27,750.00 | $ 41,625.00 | $ 55,500.00 | $ 69,375.00 | $ 83,250.00 |
| 5 | $ 32,470.00 | $ 48,705.00 | $ 64,940.00 | $ 81,175.00 | $ 97,410.00 |
| 6 | $ 37,190.00 | $ 55,785.00 | $ 74,380.00 | $ 92,975.00 | $111,570.00 |
| 7 | $ 41,910.00 | $ 62,865.00 | $ 83,820.00 | $104,775.00 | $125,730.00 |
| 8 | $ 46,630.00 | $ 69,945.00 | $ 93,260.00 | $116,575.00 | $139,890.00 |
| *For families/households with more than 8 persons add $4,720.00 | | | | | |

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ASPIRE BEHAVIORAL CONNECTIONS

# DISCOUNTED/SLIDING FEE APPLICATION

MRN#_____
DOB_____

It is the policy of ASPIRE BEHAVIORAL CONNECTIONS, LLC to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. 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 which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Client Name: _____

Number of related persons living in your household: _____

| HOUSEHOLD MEMBER | HOUSEHOLD INCOME (Complete one column) | | |
|---|---|---|---|
| | Annual | Monthly | Bi-Weekly |
| Self | | | |
| Spouse | | | |
| Dependent Children (under 18) | | | |
| Total | | | |

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self- employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

_____

Name (Print) Signature Date

**Office Use Only**
Date Received Form: _____

Date of Service: _____

Discount: _____ Approved By: _____ Last updated: 4/12/2022

ASPIRE BEHAVIORAL CONNECTIONS

# FAMILY ASSISTANCE PLAN APPLICATION

MRN#_____
DOB_____

Name of Head of Household: _____

Home Address: _____

Social Security #: _____

## PRIMARY INSURANCE

Insurance Company: _____

Policy Holder: _____ Relationship to Client: ☐ Self ☐ Spouse ☐ Child

Insurance ID: _____ Subscriber ID: _____

Group/MA#: _____ MCO: _____

## SUBSCRIBER DEMOGRAPHICS

Full Name: _____ Date of Birth: _____

Social Security #: _____ Gender: ☐ Male ☐ Female

Employer: _____ Phone#: _____

| PLEASE LIST SPOUSE AND DEPENDENTS *(under age of 18)* | | | | | |
|---|---|---|---|---|---|
| | Name | Date of Birth | | Name | Date of Birth |
| Self | | | Dependent | | |
| Spouse | | | Dependent | | |
| Dependent | | | Dependent | | |

| ANNUAL HOUSEHOLD INCOME | | | | |
|---|---|---|---|---|
| SOURCE | SELF | SPOUSE | OTHER | TOTAL |
| Gross wages, salaries, tips, etc. | | | | |
| Social security, pension, annuity, and veteran's benefits | | | | |
| Alimony, child support, military family allotments | | | | |
| Income from business, self-employment and dependents | | | | |
| TOTAL INCOME | | | | |

| VERIFICATION CHECKLIST (ATTACH COPIES) | YES | NO |
|---|---|---|
| Identification/Address: Driver's license, birth certificate, employment ID, social security card or other | | |
| Income: Prior year tax return, three most recent pay stubs, or other | | |
| Insurance: Insurance card(s) | | |
| Medicaid: Application made or evidence of rejection. | | |

I certify that the information shown above is correct and understand verification is required for approval.

_____

Name Signature(sign) Date

**Office Use Only**
Date Received Form: _____
Received & By: _____

Last updated: 4/12/2022