CROUSE HEALTH

OUTPATIENT BEHAVIORAL HEALTH SERVICES
DETERMINATION OF PATIENT FEE STATUS

Account #: _____

Patient's Name _____ _____ _____ _____/_____/_____
First Last MI Date of Birth

Address _____ _____ _____ _____
Street City State Zip Code

Phone (_____) _____-_____ **Household Size:** _____ (Please list *All* household member including the applying patient)

Name	**Date of Birth**	**Household Relationship**
1-_____	_____/_____/_____	_____
2-_____	_____/_____/_____	_____
3-_____	_____/_____/_____	_____
4-_____	_____/_____/_____	_____
5-_____	_____/_____/_____	_____
6-_____	_____/_____/_____	_____

Household Income Information (Please check appropriate box for source of income and enter gross monthly or gross annual dollar amount)

	Patient	Spouse	Other Household Income		Gross Monthly Income	Annual Income
Wages					$	$
Social Security					$	$
Pension					$	$
Disability					$	$
Unemployment					$	$
Workers Comp					$	$
VA Benefits					$	$
Child Support					$	$
Alimony					$	$
Rental Income					$	$
Interest Dividends					$	$
Other Income					$	$

2023 Charity Care Discount Guidelines For Behavioral Health Services

Amount Due Per Week*	$15	$25	$50	$80	**$100**
% of FPL	**Below** 100%	101-160%	161-250%	251-350%	350-400%
HOUSEHOLD					
1	**Below** $14,580	$14,581-23,328	$23,329-36,450	$36,451-51,030	$51,031-58,320
2	**Below** $19,720	$19,721-31,552	$31,553-49,300	$49,301-69,020	$69,021-78,880
3	**Below** $24,860	$24,861-39,776	$39,777-62,150	$62,151-87,010	$87,011-99,440
4	**Below** $30,000	$30,001-48,000	$48,001-75,500	$75,501-105,000	$105,001-120,000
5	**Below** $35,140	$35,141-56,224	$56,225-87,850	$87,851-122,990	$122,991-140,560
6	**Below** $40,280	$40,281-64,448	$64,449-100,700	$100,701-140,980	$140,981-161,120
7	**Below** $45,420	$45,421-72,672	$72,673-113,550	$113,551-158,970	$158,971-181,680
8	**Below** $50,560	$50,561-80,896	$80,897-126,400	$126,401-176,960	$176,961-202,240
Extra Person	$5,140				

The determination sliding fee status applies to all self pay accounts established and any patient responsibility after insurance processing. By providing my signature below, I certify that the above information is accurate and true to the best of my knowledge. I understand that SFS eligibility is based on my income shared to date and may be subject to change upon the receipt of additional household income throughout the duration of my program enrollment and/or a re-determination of my household income reviewed annually. I understand that once application is reviewed I will receive an approval letter with my weekly rate expectations for the program.

_____/_____/_____ _____ _____ _____
Date Time Patient Signature Preparer's Signature