Sliding Scale Program

To help ensure access to quality healthcare for everyone, YouthCare of Oklahoma offers a sliding fee scale to patients according to their income and ability to pay.

Sliding Scale applications are offered at any of our locations. You may apply regardless of whether you have other insurance coverage or not.

Patients must complete/sign the application and provide proof of their total household income. A "household" is defined as everyone living under the same roof, whether related or not.

You may submit the completed application with all required proof of income to any of our offices (or mail them to: PO Box 95207, Oklahoma City 73143). ***If the application is not signed, it will be denied. Incomplete applications will be considered void if all information is not received within 30 days.***

Acceptable proof of income:

- Most recent Income Tax Statement
- 4-current pay stubs (of everyone working within the household)
- If applicable, a copy of any benefit checks
- If applicable, a copy of the total amount of food stamps you receive each month (on Social Services letterhead)

If approved, you may only be required to pay a prorated portion of the fee for services rendered.

If you have any questions, please call one of our clinical directors at 866-926-6552.

Sliding Fee Scale Income Requirements

Assessment and Treatment Planning	$125.00
Individual Therapy (per hour) ……	$75.00
Family Therapy (per hour)……	$75.00
Group Therapy (per hour) ……....	$40.00

Sliding Fee Scale for Counseing Services - Income Based

Family Size	0%	20%	40%	60%	80%	100%
1	0 - 6810	6811 - 8513	8514 -10215	10216 - 11918	11919 - 13620	13621 +
2	0 - 9190	9191 - 11488	11489 - 13785	13786 - 16083	16084 - 18380	18381 +
3	0 - 11570	11571 - 14463	14464 - 17355	17356 - 20248	20249 - 23140	23141 +
4	0 - 13950	13951 - 17438	17439 - 20925	20926 - 24413	24414 - 27900	27901 +
5	0 - 16330	16331 - 20413	2041 - 24495	24496 - 28578	28579 - 32600	32661 +
6	0 - 18710	18711 - 23388	23889 - 28065	28066 - 32743	32744 - 37420	37421 +
7	0 - 21090	21091 - 26363	26364 - 31635	31636 - 36908	36909 - 42180	42180 +
8	0 - 23470	23471 - 29338	29339 - 35205	35206 - 41073	41074 - 46940	46941 +
9	0 - 25850	25851 - 32313	32314 - 38775	38776 - 45238	45239 - 51700	51701 +
10	0 - 28230	28231- 35288	35289 - 42345	42346 - 49403	49404 - 56460	56461 +

Income levels are based on total gross family income, less child support payments made to another household, if any. For each additional family member add $3,740 to the base. Reference: Federal Poverty Level Guidelines, 2009.

Sliding Fee Scale Percentage _____%

I, _____ understand that the fee stated above is the fee I am responsible to pay for counseling services. I further understand that this fee is due in the form of cash, check or money order at the time that services are rendered.

Client Name: _____ Date: _____

NOTE:

Check or money orders must be made payable to YouthCare of Oklahoma

Proof must accompany application.
Acceptable proof includes: Most recent Income Tax Statement, 4-current pay stubs, a copy of benefit checks, etc.

YOUTHCARE of OKLAHOMA

Applicant _____ Phone _____

Address _____ City/State _____ Zip _____

I certify that all statements contained herein are true and correct and subject to investigation. I also authorize the release of employment records and other financial information to an agent of the YouthCare of Oklahoma for sliding fee determination purposes.

_____ _____ _____ _____
Applicant's Signature *Date* *Signature of Spouse* *Date*

APPLICANT _____ Date of Birth _____ SSN _____
Employer _____ Hourly wage $_____ Hours/week _____
Employer Address _____ Annual Salary $_____ Other Income _____
Health Insurance _____

SPOUSE _____ Date of Birth _____ SSN _____
Employer _____ Hourly wage $_____ Hours/week _____
Employer Address _____ Annual Salary $_____ Other Income _____
Health Insurance _____

OTHER MEMBERS OF THE HOUSEHOLD: (Everyone living under the same roof – whether related or not)
Continue on back of form if necessary.

Name _____ Date of Birth _____ SSN _____
Employer _____ *Annual Income $_____
Health Insurance _____ Relationship to Applicant _____

Name _____ Date of Birth _____ SSN _____
Employer _____ *Annual Income $_____
Health Insurance _____ Relationship to Applicant _____

Name _____ Date of Birth _____ SSN _____
Employer _____ *Annual Income $_____
Health Insurance _____ Relationship to Applicant _____

*** Include Income from all sources:** Wages, Social Security, Disability, Retirement, Veteran Benefits, Aid to Dependent Children, Rental Assistance, Child Support, Farm, Alimony, Self-Employment, Rental Income, Interest and Dividends, etc.

I, the applicant signed below, testify that all of the information provided is true and accurate. I further agree that any false information contained on this application will make it null and void and will result in the denial of reduced fees for services rendered.

_____ _____ _____ _____
Applicant's Signature *Date* *Signature of Spouse* *Date*

This section is to be completed by the YCO staff

Family Size _____ Total Household Gross Income $_____ Level _____

Approved by _____ Date _____ Expiration Date _____

Sliding Fee Application Guidelines

Please record all of the resources available to you to provide for the basic needs of food, shelter, and health care.

A "household" is defined as everyone living under the same roof, whether related or not. The scale is not designed for individual family units to be compared separately within the household. It also does not matter if everyone in the household is contributing financially to the household, or if everyone in the household is a patient of the clinic.

***The following information must be provided on the sliding fee application*:**

1. A list of all individuals in your household.
2. The current employment status of all members of the household. Include the name and address of the employer and the current rate of pay. If an individual is unemployed or retired, we will need to know about any unemployment benefits, social security, veterans benefits, SSI, etc.
3. List household income from all sources. This includes interest, dividends, pensions, rental assistance, food stamps, Aid for dependent children, child support, alimony, capital gains, etc.
4. List of all health insurance carriers and whether pharmacy benefits are included.
5. Are there any circumstances such as recent unemployment, application for disability or is someone outside of the household responsible for any members of the household's health care?

If you have no income, or your household income is less than $10,000, then we need the following questions answered and attached to the application:

1. Monthly rent or mortgage? Rent $_____ Mortgage $_____
2. Monthly Phone bill $_____ Monthly Power bill $_____
3. Do you own a car? _____ Monthly payments $_____
4. Are you on any chronic medications? _____ Amount $_____
5. Do you receive any public assistance? **(PROOF REQUIRED FOR THESE ITEMS!)**

   AFDC _____ Food Stamps _____ SSI _____

You may deduct child support made to another household if proof is provided. Acceptable income proof includes: **A COMPLETE copy of your current income tax form AND 4 current pay stubs or receipts**.

*Please attach a note to your application to explain any special situations or circumstances. Ask for help if you need it. You will be required to sign the application, giving permission to certify and verify its contents.

Return this application and all proof of income to any of our locations or mail it to:

YouthCare of Oklahoma
PO Box 95207
Oklahoma City, OK 73143