

Wilson Psychological Associates, PLLC
Sliding Fee Discount Application

It is the policy of Wilson Psychological Associates to provide essential mental health services regardless of the patient's ability to pay. *Discounts are offered based on family size and annual income.* 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 except any Forensic Work (for legal purposes rather than clinical/mental health). This form must be completed every 12 months or if your financial situation changes.

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

SLIDING FEE DISCOUNT APPLICATION

Name of Head of Household			Place of Employment	
Street	City	State	Zip	Phone

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business self employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, military family allotments, interest, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Print Name

Date

Signature

Date

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved By: _____

Date Approved: _____

Effective Date: _____

Expiration Date: _____

VERIFICATION CHECKLIST (ATTACH COPIES)	YES	NO
Identification/Address: Driver's License, utility bill, employment ID, or other		
Income: Prior year tax return, two (2) most recent pay stubs, letter from employer, Form 4506-T (if W2 not filed) or other		
Health Insurance: Insurance Card(s)		
Medicaid: Verification of application made or evidence of rejection of application		

SLIDING FEE DISCOUNT PROGRAM

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)

Poverty Level	*100%*	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
			D	I	S	C	O	U	N	T		
Family Size	Discount 100% \$10	Discount 100% \$10	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 10%	Discount 0%
1	\$12,760	14,036	15,312	16,588	17,864	19,140	20,416	21,692	22,968	24,244	25,520	25,521+
2	\$17,240	18,964	20,688	22,412	24,136	25,860	27,584	29,308	31,032	32,756	34,480	34,481+
3	\$21,720	23,892	26,064	28,236	30,408	32,580	34,752	36,924	39,096	41,268	43,440	43,441+
4	\$26,200	28,820	31,440	34,060	36,680	39,300	41,920	44,540	47,160	49,780	52,400	52,401+
5	\$30,680	33,748	36,816	39,884	42,952	46,020	49,088	52,156	55,224	58,292	61,360	61,361+
6	\$35,160	38,676	42,192	45,708	49,224	52,740	56,256	59,772	63,288	66,804	70,320	70,321+
7	\$39,640	43,604	47,568	51,532	55,496	59,460	63,424	67,388	71,352	75,316	79,280	79,281+
8	\$44,120	48,532	52,944	57,356	61,768	66,180	70,592	75,004	79,416	83,828	88,240	88,240+
For each additional person, add	4,480	\$4,928	5,376	5,824	6,272	6,720	7,168	7,616	8,064	8,512	8,960	8,960

Based on 2020 Federal Poverty Guidelines