LIVING HOPE COUNSELIG CENTER

2200 S 6th St. Springfield, IL 62703 Phone: (217) 698-7150

APPLICATION FOR SLIDING SCALE

Living Hope Counseling Center provides professional counseling and strives to empower people to find wholeness and emotional healing regardless of their financial circumstances. If a client does not have access to affordable counseling services through insurance and is unable to access services through state or federal programs, we offer sliding scale rates based on your yearly household income. Our subsidized funds are limited and may not be able to offer these rates to individuals who have Medicare, Medicaid or other out of network programs or insurance.

To apply for sliding scale there are documents that are required to be considered. These documents are:

1. **A copy of your most recent tax return.**
2. **The two most recent pay stubs or benefit statement for any form outside of employment.**
3. **Alternative Information that may be required are Termination Notice, Last Two Months of Bank Statements, Explanation of Disability, Unemployment Benefits and/or other approved documents.**

To receive sliding scale rates, we ask for you to have your documents and your application to the office prior to your first appointment. Documentation can be provided in the following ways:

1. Mail documents and application to the Office Manager at our address listed above.
2. Fax documents to 217-698-7085.
3. Bring the documents by our office during normal business hours.
4. Request to set up a patient portal to upload the documents.

EMAIL IS NOT SECURE. PLEASE DO NOT EMAIL ANY PERSONAL INFORMATION TO THE OFFICE

Once the application is reviewed the office will be able to tell you which rate you qualify for. The rates are listed below.

RATE	$20 per session for 8 sessions	$50 per session for 16 sessions	$80 per session	$150 per session
Family Size	Annual Household Income Level			
1 person	< $24,980	$25,000 - $31,225	$31,230 - $49,950	$49,960 and up
2 people	< $33,820	$33,830 - $42,275	$42,280 - $67,630	$67,640 and up
3 people	< $42,660	$42,670 - $53,325	$53,450 - $85,315	$85,320 and up
4 people	< $51,500	$51,510 - $64,375	$64,440 - $102,999	$103,000 and up
5 people	< $60,340	$60,350 - $75,425	$75,450 - $120,670	$120,680 and up
6 people	< $69,180	$69,190 - $86,475	$86,500 - $138,350	$138,360 and up
7 people	< $78,020	$78,030 - $97,525	$97,550 - $156,030	$156,040 and up
8 people	< $86,860	$86,870 - $108,575	$108,600 - $173,510	$173,520 and up
Each additional Person	$4,420	$8,840	$13,260	N/A

*Each person paying at a sliding scale rate of $20 or $50 is limited to receiving a maximum of $500 of subsidy funds. Your counselor and/or the administrative staff will provide continued communication regarding the amount of funds used and work with you to determine the best option moving forward.

*Admin staff may request updated verification documents throughout the provided services.

Client Information		
Client Name:		Date of Birth:
Full Address:		
Phone Number:		
Parent/Guardian for Minors:		
Income Information: (Required)	Employer Name:	
Gross Individual Income (Annual): $_____	Gross Family Income (Annual): $_____	Family Size:

____ I certify the client is not covered by any out of network insurance benefits and client does not have access to services through state or federal programs (including Medicare, Medicaid, or other public assistance insurance) for which Living Hope Counseling Center cannot bill. I understand that I can continue to receive the sliding scale assistance rate up to the maximum limit established by Living Hope Counseling Center policies and until the client is covered by other out of network benefits.

Client/ Parent/ Guardian Signature: _____ Date: _____

____I certify that the information concerning my family size and income is current and accurate. I agree to notify Living Hope Counseling Center of any changes in this information. Living Hope Counseling Center will review this information and remains the right to request updated paperwork to verify your current income status.

Client/ Parent/ Guardian Signature: _____ Date: _____

____ I certify that I am choosing to provide these documents to be considered for sliding scale rates. Living Hope Counseling Center will establish the amount the client is to pay per session and the number of total sessions based on the income information you provided. If you choose not to provide proof of income, your application may be declined.

Client/ Parent/ Guardian Signature: _____ Date: _____

****Office Use Only****

Paperwork received: _____ Date: _____

Final Approval: _____ Date: _____

The above client is eligible to receive sliding scale rate of $_____ per one-hour sessions.