Northwest Neurobehavioral Health, LLC
Sliding Fee Discount Application

It is the policy of Northwest Neurobehavioral Health, LLC (NNH) to provide essential mental health services regardless of the client's inability to pay. Discounts are offered based upon household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. If a patient is at or below 100% of the Federal Poverty Level, a nominal flat rate fee of $10 will be assessed for each appointment. Once approved, the discount will be honored for the date range listed below or for four (4) months from the approval date, after which the client must reapply.

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 mental health services received at this clinic, but not those services for which you may be referred. Please notify us immediately if your financial situation changes. Payment for discounted services is expected at the time of service.

Patient's Name: _____ DOB: _____

Number of related persons living in your household: _____

Total household income: Complete one of the columns below

Household Member	Gross Annual Income	Gross Monthly Income	Gross Bi-Weekly Income
Self			
Spouse			
Dependent children under age 18			
TOTAL			

Note: Include income from all sources including gross wages, tips, social security, disability, Supplemental Income, survivor benefits, retirement income, interest, dividends, rents, income from estates, trustees, educational assistance, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and workers' compensation (housing subsidies and food stamps do not apply)

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income will be required before a discount is approved. If not earning an income, please provide a brief statement explaining how living expenses are being covered.

_____ _____ _____

Name of responsible party (please print) **Signature** **Date**

2463 E. Gala Street #100, Meridian Idaho 83642-4800 *Phone #208-955-7333 *Fax #208-955-7330

Office Use Only

Patient Name: _____ DOB_____ Account #: _____

( ) Approved: Discount _____ Patient Responsibility _____ Write-off _____

( ) Denied: Above Federal Poverty Guidelines, ( ) Other _____

( ) Incomplete: Missing and/or incomplete documentation, ( ) Other_____

Approved Dates:_____ Service/CPT(s): _____

Reviewed by: _____ Date: _____

Provider: _____ ( ) Accepted ( ) Denied, Referred to: _____

Provider: _____ ( ) Accepted ( ) Denied, Referred to: _____

Provider: _____ ( ) Accepted ( ) Denied, Referred to: _____

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Income				Total
Household Gross Monthly Income $	Monthly Take Home Income$	Other (list) $	Other (list) $	N/A
Alimony $	Child Support $	Disability $	SS Benefits $	N/A
Retirement/Pension $	Unemployment $	Food Stamps $	Welfare $	N/A
Total of Income				$

Expenses	Paid to Whom	Owing	Value	Payment
Rent or Mortgage		$	$	$
Power		$	N/A	$
Gas		$	N/A	$
Water		$	N/A	$
Trash & Sewer		$	N/A	$
Telephone/Cell		$	N/A	$
Cable		$	N/A	$
Medical Insurance		$	N/A	$
Auto Insurance		$	N/A	$
Life Insurance		$	N/A	$
Prescriptions		$	N/A	$
Medical Bills (list on separate sheet)		$	N/A	$
Total Vehicle Payment		$	$	$
Transportation Cost		$	N/A	$
Credit Cards (list additional on separate sheet)		$	Available Credit Limit $	$
Student Loan		$	N/A	$
Child Care Cost		$	N/A	$
Food/household Supplies		$	N/A	$
Other Expenses (explain)		$	$	$
		$	$	$
		$	$	$
Total of Expenses				$
Subtract Income from Expenses				$