

LIVING HOPE COUNSELING CENTER
3000 Lenhart Road, Springfield, IL 62711 Phone: 217-698-7150

APPLICATION FOR SLIDING SCALE RATES

Living Hope Counseling Center provides professional counseling services from a faith-based perspective and strives to empower people to find wholeness, emotional healing and Living Hope through counseling services, 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 annual family household income. Because our subsidized funds are limited, we cannot currently offer these sliding scale rates to those who have Medicare, Medicaid, or other out-of-network programs or insurance.

To apply for the sliding scale rates, please complete the attached application and provide BOTH:

- 1) A copy of your most recent tax return
- 2) The two most recent pay stubs or benefits statement for any other form of benefits outside of employment.

To receive the sliding scale rate and not be charged the full standard rate, we MUST receive the application and documentation prior to the appointment for which you want to be considered. The documentation can be provided in any of the following ways:

- 1) Mail the documents and application to Office Manager at the address listed above.
- 2) Fax the documents to 217-698-7085, attention Office Manager.
- 3) Bring the documents to the main office listed above during normal administrative hours.
- 4) Upload scanned documents or pictures of the documents to your secure client portal. Call the office to get access.

Email is NOT a secure method of communication. Please DO NOT EMAIL the documents to the office.

Once the application is reviewed, you will be contacted prior to your first appointment with your rate. Your sliding scale will be based on the following schedule of income guidelines. The amounts listed are annual total household income.

RATE ->	\$20 Per Session	\$50 per session	\$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	63,990 - \$85, 315	\$85,320 and up
4 people	< \$51,500	\$51,510 – \$64,375	\$77,250 - \$102,999	\$103,000 and up
5 people	< \$60,340	\$60,350 - \$75,425	\$90,510 - \$120,670	\$120,680 and up
6 people	< \$69,180	\$69,190 - \$86,475	\$103,770 - \$138,350	\$138,360 and up
7 people	< \$78,020	\$78,030 - \$97,525	\$117,030 - \$156,030	\$156,040 and up
8 people	< \$86,860	\$86,870 - \$108,575	\$130,290 - \$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 assistance. 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 for you when your funds are exhausted.

LIVING HOPE COUNSELING CENTER
Sliding Scale Income Verification

(Please review the attached instructions before completing this form.)

DEMOGRAPHICS (Required)

Client Name	Date of Birth
Full Address	
Phone Number:	
Parent/Guardian for Minors:	

INCOME INFORMATION: (Required)

EMPLOYER NAME		EMPLOYER PHONE
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: _____

Proof of Income Documentation must be presented prior to the first appointment. Without documentation, we will collect the standard hourly rate of \$150 until documentation is provided. Please a copy of BOTH 1) the most recent tax return and 2) the two most recent paystubs from each adult providing income in the household. (Both are required).

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 every other month by requesting updated paystubs to verify your continued eligibility for subsidized counseling sessions.

Client/Parent/Guardian Signature: _____ Date: _____

DOCUMENTATION OF CHOICE TO RECEIVE SLIDING SCALE RATES: If you meet the income eligibility criteria, 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 written proof of your income, you may decline to be a recipient of subsidized sessions.

Client/Guardian/Parent Signature: _____ Date: _____

The above-named client is eligible to receive the sliding scale rate of \$_____ per one-hour session.

FINAL APPROVAL by _____ Date: _____