



1411 Wesley Drive
Salisbury, MD 21801
Office 410-642-4011 Fax 410-630-1654

APPLICATION FOR SLIDING FEE SCALE

It is the policy of Evolve Mental Wellness, LLC to provide behavioral health services regardless of the patient's ability to pay. Evolve Mental Wellness, LLC offers discounts based on family size and annual income. Please complete the following information and return to the Business Office Manager to determine if you or members of your family are eligible for a discount. The discount will apply to all services at our agency, but not those services outside, including laboratory tests. You must complete this form every 12 months or if your financial situation changes.

" PLEASE PRINT "

Date: ____/____/____

Patient's Name: _____ Patient's Date of Birth: ____/____/____

Responsible Party / Spouse Name: _____

Responsible Party / Spouse Date of Birth: ____/____/____

Responsible Party/ Spouse Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Do you, or the patient you represent, have medical insurance? ☐ Yes ☐ No

If YES, please provide your insurance card to the front desk representative.

Have you applied for Medical Assistance? ☐ Yes ☐ No

If eligible, please provide Medical Assistance Member #: _____

Are you a Maryland resident? ☐ Yes ☐ No

IF YOU **DO NOT HAVE INSURANCE**, PLEASE ASK FOR ASSISTANCE FROM THE APPLICATION COUNSELOR.

Have you applied for MCHP (Maryland Children's Health Program)? ☐ Yes ☐ No

Do you have a State of Maryland pharmacy card? ☐ Yes ☐ No

If yes, list identification #: _____

Eligibility for Evolve Mental Wellness's sliding fee scale financial assistance is based on income levels relative to the federal poverty guidelines published annually and the number of individuals living in your household. Certain sources of income are excluded from the calculation of household income (see below).

Please list the following MEMBERS of your household (self, spouse, significant other, and children, including step-children and legally adopted children, up to 18 years of age) and list ALL income earned by the listed members

(Proof of income for all listed must be returned within 7 days or at next scheduled appointment, whichever comes first.)

Name	Relationship	DOB	Social Security # (if applicable)	Yearly Income
	SELF			

Comments: _____

If no members of your household earn income used to calculate eligibility for the sliding fee scale, please check the box below and the appropriate box within the Means of Support.

☐ I attest that all members of my household have **NO INCOME**.

Please note that all applications must be updated annually.

Documents Accepted as Proof of Income (POI):

- ☐ Pay Stubs (minimum: 1 pay stub)
- ☐ W2 Tax Form
- ☐ Tax Return Form #1040 (Line 9) **(total income)**
- ☐ Tax Return Form #1040SR (Line 9) **(total income)**
- ☐ Social Security (Staff: READ Contents of Letter)
- ☐ Unemployment (for 6 months)
- ☐ Letter from Employer

If You Attest to No Income, Please Check Means of Support:

- ☐ Disability
- ☐ Child Support
- ☐ Workers Compensation
- ☐ Temporary Cash Assistance
- ☐ SSI (Supplemental Security Income)
- ☐ Social Security Disability
- ☐ Live with other family member
- ☐ Other _____

Please answer the following survey questions:

Evolve Mental Wellness's nominal fee for behavioral health services is \$25. Do you feel this charge is (check one):

☐ Fair/Adequate ☐ Too Expensive ☐ Would Prevent Me From Seeking Care

If you checked "Too Expensive or Would Prevent Me From Seeking Care" please provide your opinion of an appropriate fee: \$_____

I certify under penalties of perjury, that the above statements are true, accurate and complete to the best of my knowledge and belief.

Applicant / Guarantor's Signature

Date

FOR OFFICE USE ONLY

Has patient been referred to the Certified Application Counselor (CAC)?

☐ Yes

☐ No

Please write name of CAC: _____

Monthly: _____ X $\frac{12}{12 \text{ mo.}}$ = _____
in Household Gross Total Amount

Weekly: _____ X $\frac{52}{52 \text{ weeks}}$ = _____
in Household Gross Total Amount

Bi-Weekly: _____ X $\frac{26}{26 \text{ weeks}}$ = _____
in Household Gross Total Amount

Annual: _____ X $\frac{1}{1 \text{ year}}$ = _____
in Household Gross Total Amount

Qualifying Level:

☐ Nominal

☐ Level I

☐ Level II

☐ Level III

Medical Receptionist Printed Name: _____ Site: _____

Medical Receptionist Signature: _____ Date: _____