Meridian
BEHAVIORAL HEALTH SERVICES
Hope. Heal. Recover.

Sliding Fee Scale Application / State Funding Criteria (2020 Guidelines)

It is the policy of Meridian Behavioral Health Services, Inc. (Meridian) that all Meridian direct consumers (those not supported by state funding, Medicaid, Medicare or Health Choice) will be assessed a fee for services rendered. All services eligible for fee reduction will be assessed on a sliding fee scale based on the current year Federal Poverty Guidelines. This information is also listed in the Client's Rights Brochure. To qualify for Meridian's sliding fee scale, you must provide income verification. Additionally, in some circumstances, state funding is available for individuals whose income is 300% or below the federal poverty guideline. In no cases will access to Meridian's basic services be denied to a consumer solely based on an inability to pay a fee.

ANNUAL HOUSEHOLD INCOME						
Household Size	**100% OR BELOW**	**101-130% FPL**	**131-170% FPL**	**171-200% FPL**	**201% -300%**	**301% +**
1	$12,880	$12,881 - $16,744	$16,745 - $21,896	$21,897 - $25,760	$25,761 - $38,640	$38,641 +
2	$17,420	$17,421 - $22,646	$22,647- $29,614	$29,615- $34,840	$34,841 - $52,260	$52,261 +
3	$21,960	$21,961 - $28,548	$28,549 - $37,332	$37,333- $43,920	$43,921- $65,880	$65,881 +
4	$26,500	$26,501 - $34,450	$34,451 - $45,050	$45,051- $53,000	$53,001 - $79,500	$79,501 +
5	$31,040	$31,041 - $40,352	$40,353 - $52,768	$52,769- $62,080	$62,081 - $93,120	$93,121 +
*Add $4,540 per year for each additional household member.						
Discount Level	**5**	**4**	**3**	**2**	**1**	**0**
BASIC SERVICES						
Basic % Discount	**Nominal Fee**	**70%**	**50%**	**30%**	**0%**	**0%**
Individual Therapy	$5.00	$33.00	$55.00	$77.00	$110.00	$110.00
Family Therapy	$5.00	$33.00	$55.00	$77.00	$110.00	$110.00
Group Therapy	$5.00	$22.50	$37.50	$52.50	$75.00	$75.00
Clinical Assessment	$5.00	$52.50	$87.50	$122.50	$175.00	$175.00
Psych/Clinic Evaluation	$5.00	$68.40	$114.00	$159.60	$248.00	$248.00
Psych/Clinic Follow-up	$5.00	$68.40	$114.00	$159.60	$248.00	$248.00
SPECIALTY/ENHANCED SERVICES						
Suboxone Intake	$11.00	$33.00	$55.00	$77.00	$110.00	$110.00
Suboxone Re-Check	$97.00	$134.75	$172.50	$210.25	$248.00	$248.00
Urine Drug Screen	$4.00	$12.00	$20.00	$28.00	$40.00	$40.00

Sliding Fee Scale Application / State Funding Criteria

CLIENT NAME:		**DATE ASSESSED:**	
Name	**Date of Birth**	**Name**	**Date of Birth**
Self		Other Family Member/Dependent	
Spouse		Other Family Member/Dependent	
Other Family Member/Dependent		Other Family Member/Dependent	

Total Adults in Family: _____

Total Adults and Children in Family: _____

Total Children (<18) in Family: _____

Source	**Self**	**Spouse**	**Other**	**Total**
Gros wages, Salary, Tips, etc.				
Income from business, self-employment, and dependents				
Unemployment/workers compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension/retirement income				
Interest, dividends, rent, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other misc. sources				
TOTAL INCOME				

Discount Level Eligibility: (please check one)

☐ Level 5 ☐ Level 4 ☐ Level 3 ☐ Level 2 ☐ Level 1 ☐ Level 0 ☐ N/A – client is eligible for state funding.

Sliding fee scale assessments are updated at minimum annually or at the time of a qualifying event, including but not limited to becoming employed, unemployed, a long-term reduction/increase in hours, and / or change in pay rate. Sliding fee scale assessments shall be applied to services up to 6 months retroactively and 12 months after the approved date. All applicable charges are expected prior to being seen. If unable to pay for services as agreed, contact Meridian's billing department at (828) 631 – 3973 ext. 1001.

I certify that the information provided on this form is accurate to the best of my knowledge. If found to be inaccurate, I understand that any discount for which I was eligible may no longer be valid and I may be subject to the full charge for services provided. If there is a change in my financial situation, I will notify Meridian staff prior to my next appointment. Failure to notify Meridian staff of a change in my financial status may result in termination of this agreement and I may be subject to the full charge for services provided. I understand that payment is due at the time of service and I will be asked to make a payment when I check in for my appointment, however I will not be denied access to Meridian's basic services solely based on the inability to pay.

Signature: _____ Date:

Meridian Staff: _____ Date:

Meridian
BEHAVIORAL HEALTH SERVICES
Hope. Heal. Recover.

No Proof of Income/Support Letter

Name:	**Date of Birth:**
Please provide the following information for person(s) providing you with financial support.	

Name: _____ **Relationship:** _____
Address: _____ **Phone Number:** _____
_____

TO BE COMPLETED BY THE PERSON PROVIDING FINANCIAL SUPPORT:
Meridian's fees are based on the type of service provided as well as the individual's income and family size. The above-named individual has listed you as a person providing financial support to him/her. Please answer the following questions to help us better understand the level of financial support you provide to this individual.

Does this individual currently live with you?

☐Yes, this person has lived with me for ___ year(s) ___month(s) ___ day(s)

☐ No, this person does not live with me.

What type of support do you provide to this person?

☐ Food ☐ Housing ☐Utilities ☐Health Care ☐ Money ☐Other support

Please provide a brief description of the situation:

_____
_____
_____
_____
_____

I certify that the information I have provided is accurate to the best of my knowledge.

_____
SIGNATURE OF FINANCIAL SUPPORTER **DATE**

I certify that the information provided on this form is accurate to the best of my knowledge. If found to be inaccurate, I understand that any discount for which I was eligible may no longer be valid and I may be subject to the full charge for services provided. If there is a change in my financial situation, I will notify Meridian staff prior to my next appointment. Failure to notify Meridian staff of a change in my financial status may result in termination of this agreement and I may be subject to the full charge for services provided. I understand that financial eligibility may be evaluated at least annually.

_____
SIGNATURE OF SERVICE RECIPIENT **DATE**