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MENTAL HEALTH ACCESS PROGRAM – FEE SUBSIDY APPLICATION

SamaraCare understands the costs of managing a mental health condition can be overwhelming – especially if you're dealing with a financial hardship. This is why we offer fee subsidy assistance through our Mental Health Access Program (MHAP). Our fees are determined using a sliding fee scale based on gross household income and family size. Other extenuating factors may be taken into consideration. **Please complete this application and return it to your counselor during intake, along with the required financial information. All MHAP applicants are required to provide proof of household income.**

APPLICANT INFORMATION

Applicant Name: _____

Are you a parent/guardian completing this application on behalf of an adult or minor: ❑ Yes ❑ No

If yes, please provide the name of the adult or minor.

Client Name:_____

Address:_____

City:_____ **State**_____ **Zip**_____

Client county of residence: ❑Cook ❑DuPage ❑Kane ❑Kendall ❑ Lake ❑Will ❑Other_____

Township of Residence (if known)_____

Client marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

How were you referred to SamaraCare? ❑ Insurance ❑ Physician ❑ School ❑ Church ❑ Friend ❑ Non-Profit Organization ❑ Google Search ❑ Other _____

Counselor Name: _____

ELIGIBILITY QUESTIONS

1. Please check one box that best describes your financial hardship:
   ❑ Low/Moderate income household ❑ Unemployed ❑ Long-term Disability/Unable to Work
   ❑ No health insurance ❑ High deductible insurance plan ❑ Insurance benefits exhausted
   ❑ Counseling services not covered by insurance ❑ Other financial hardship

2. If you checked "Other financial hardship, please check one box that best describes your hardship:
   ❑ Recent separation/divorce ❑ Subjected to physical, sexual or emotional abuse
   ❑ Subjected to spousal abandonment ❑ Death of primary household wage earner
   ❑ Extraordinary medical expenses ❑ Bankruptcy
   Please explain _____
   _____
   _____

   Has your employment changed since your last tax return: ❑ Yes ❑ No

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If yes; please explain _____
_____

3. Has your household income changed since your last tax return? ❑ Yes ❑ No
   If yes: please explain_____

4. Do you or any of your household members have a Health Savings Account or Flex Spending Account? ❑ Yes ❑ No
   If yes, what is the estimated value of the account?_____

5. Do you expect any changes to your household income in the near future? ❑ Yes ❑ No
   If yes, please explain_____

HOUSEHOLD INCOME/SIZE INFORMATION

1. Total number of people living in your household: Total_____ ; Adults _____ Children _____

2. Please provide your gross (before taxes) household income for last year:_____
   Include all sources of income e.g. salaries, wages, social security, unemployment, disability income, retirement income, investments etc. for each individual who contributes to the household income.

   Please note if you are subjected to domestic abuse or spousal abandonment you may apply, as a separate household, without concern of your application being denied for misrepresenting your marital status and/or household income.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I understand and accept the following terms and conditions:

- the applicant must be an active SamaraCare client.
- if I do not provide proof of income or accurate information, I am ineligible for financial assistance.
- if there are any changes in my financial situation, I must notify SamaraCare within 15 days of the change and update my income information accordingly.
- this application is good for up to one year and I must re-qualify annually to maintain eligibility.
- the only charges subsidized by the MHAP are for in-person office visits or virtual (teletherapy) visits that include counseling and/or psychological testing and assessment services at any of SamaraCare's offices. Missed or late cancel appointment fees are not covered.
- that guidelines for fee subsidies are reviewed annually
- all payments due from the client are payable at the time of service.

My signature below certifies under penalty of perjury that all information provided is true, accurate and complete to the best of my knowledge. I understand that providing false information will result in MHAP discounts being revoked and the full balance of the account(s) restored and payable immediately.

Signature:_____ **Date:**_____

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FOR OFFICE USE ONLY:

Client Name_____

Parent/Guardian Name (if client is a minor) _____

_____

Primary Document (1 of the following)

√	Income Type	Proof of Income (all members of household)
	Salaries/Wages	Last 30 days of paystubs or Copy of signed Federal income tax return or Copy of W-2 for all household wage earners 18 yrs of age or older
	Self Employed	Copy of signed Federal income tax return
	Social Security/Pension	Copy of Award statement or Proof of Income letter
	Disability	SSDI Award statement
	Unemployment	Benefit Notification Letter signed & dated by State of IL
	Veteran Benefits	Benefit Award Letter
	Welfare Assistance	TANF Award Letter

Additional Documents (as needed)

√	Financial Hardship	Additional Documentation
	Extraordinary Medical Debt	Copy of hospital and/or medical bills
	Divorce/Separation	Divorce Decree or Separation Agreement signed by court
	Death of Primary Wage Earner	Death Certificate or Obituary
	Insurance-related (high deductible, no benefits for mental health, benefits exhausted)	Health Coverage Information Statement Form 1095-B or Form 1095-C or Health Insurance Marketplace Statement, Form 1095-A.

Sliding Fee Scale Level Approved: _____

Client Fee Per Session: $_____ Fee Subsidy Per Session: $_____ # of Sessions _____

_____ _____

Clinician **Date**

_____ _____

President/CEO or Clinical Director **Date**