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MENTAL HEALTH ACCESS PROGRAM (MHAP) COUNSELING APPLICATION

SamaraCare understands the costs of managing a mental health condition can be overwhelming – especially if you're uninsured, under-insured and/or facing a financial hardship. Our Mental Health Access Program helps minimize cost barriers to accessing high-quality mental health services by providing reduced cost care. MHAP counseling 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 your intake session, along with the required financial documentation. All MHAP applicants are required to provide documented proof of household income.

APPLICANT INFORMATION

Client/Minor Full Legal Name:____

Address: ____

City: ____ State______ Zip ______________

County: □ Cook □ DuPage □ Kane □ Kendall □ McHenry □ Lake □Will

□ Other-Illinois County:________________ □ Out of State: __________________

Township (if known): ____

Date of Birth____/____/______ Current Age______

Spouse/Guardian Name:____

Client Gender:

□ Male □ Female □Transgender □ Non-Binary □ Prefer not to disclose

Client Race/Ethnicity:

□ American Indian/Alaskan Native □ Asian □ Black/African American

□ Hispanic/Latino American □ Middle Eastern/North African □ Multi-Racial

□ Native Hawaiian or Pacific Islander □ White/Caucasian □ Prefer not to disclose

Client Relationship Status:

□ Single □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed

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: ____
____
____

3. Has your employment changed since your last tax return: ❑ Yes ❑ No
   If YES, please explain:____
   ____
   ____

4. Has your household income changed since your last tax return? ❑ Yes ❑ No
   If YES, please explain: ____
   ____

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

6. 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 every 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 is an active SamaraCare client.
- if I do not provide proof of income or accurate information, I am ineligible for reduced cost care.
- 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 valid 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 reduced cost care are reviewed annually
- all payments due from the client are payable at the time of service.

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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:_______________

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: _________ (refer to Sliding Fee Scale)
Counseling Fee: $185/clinical hour; thereof Client Fee: $__________ Reduced fee: $_________
# of Sessions if applicable ______.

Signature: Date:

____ ________________

Clinical Operations Coordinator

Revised 2/6/2025