CNS Healthcare offers a sliding fee discount

The Sliding Fee Scale is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all eligible patients. While the fee schedule is designed to cover reasonable costs for providing services, the purpose of the Sliding Fee Scale is to address financial barriers to care.

Therefore, the Sliding Fee Scale enables the provision of services to individuals consistent with their ability to pay for such services. Once established, the Sliding Fee Scale must be revised annually, at a minimum, to reflect annual updates to the Federal Poverty Guidelines.

Determining your eligibility for the sliding fee discount requires verification of your income. This information must be updated at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept completely confidential.

Do You Qualify for a Discounted Rate?

CNS Healthcare offers a sliding fee discount. Eligibility for the sliding fee discount is determined by documented annual income and family/household size. Patients with a documented annual income of 200% or below the federal poverty level (FPL) are eligible for a sliding fee discount on all services provided by CNS Healthcare.

Patients with incomes at or below 100% of the federal poverty level (FPL) are charged a nominal fee; however, no patient will be refused services due to an inability to pay.

Determining your eligibility for the sliding fee discount requires verification of your income. This information must be updated at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept completely confidential.

Documentation Required for Sliding Fee Application

1. You MUST Provide ONE of the Following Items

- Pay Stubs (Your household's pay stubs for the most recent four (4) weeks.)
- Employer Letter Verifying Employment
- Unemployment Benefit Summary Letter (Only if collecting unemployment.)
- If You Have No Income: Provide a notarized letter from a person you know (not related to you) verifying, you have no income and stating your living arrangements such as food and shelter.

2. Proof of Identity

This can be a Government-issued ID card, Current Driver's License from any state, School ID, Birth Certificate or Passport.

3. Financial Documents

A copy of your recent tax records or bank statements may be requested.

4. Other

Other items that may be requested if available are: Veterans, Social Security or Pension Benefits documentation, Child Support/Alimony verification, Workman's Comp verification

Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. Information and forms can be obtained from the Front Desk and the Business Office or at CNS Healthcare website, cnshealthcare.org .

Sliding Fee Discount Scale

2024 CNS Healthcare Sliding Fee Scale - Behavioral Health

Slide Category		A	B	C	D	E
Poverty Level		0 - 100%	101 - 200%	201 - 300%	301 - 400%	> 400%
Behavioral Health	Required Fee per family member, per visit	**Nominal Fee $5**	**$10**	**$20**	**$30**	**100% of Charges**
FAMILY SIZE						
1	Annual (up to)	**$ 15,060.00**	**$ 30,120.00**	**$ 45,180.00**	**$ 60,240.00**	**$ 60,241.00**
	Monthly	$ 1,255.00	$ 2,510.00	$ 3,765.00	$ 5,020.00	$ 5,020.08
	Weekly	$ 289.62	$ 579.23	$ 868.85	$ 1,158.46	$ 1,158.48
2	Annual (up to)	**$ 20,440.00**	**$ 40,880.00**	**$ 61,320.00**	**$ 81,760.00**	**$ 81,761.00**
	Monthly	$ 1,703.33	$ 3,406.67	$ 5,110.00	$ 6,813.33	$ 6,813.42
	Weekly	$ 393.08	$ 786.15	$ 1,179.23	$ 1,572.31	$ 1,572.33
3	Annual (up to)	**$ 25,820.00**	**$ 51,640.00**	**$ 77,460.00**	**$ 103,280.00**	**$ 103,281.00**
	Monthly	$ 2,151.67	$ 4,303.33	$ 6,455.00	$ 8,606.67	$ 8,606.75
	Weekly	$ 496.54	$ 993.08	$ 1,489.62	$ 1,986.15	$ 1,986.17
4	Annual (up to)	**$ 31,200.00**	**$ 62,400.00**	**$ 93,600.00**	**$ 124,800.00**	**$ 124,801.00**
	Monthly	$ 2,600.00	$ 5,200.00	$ 7,800.00	$ 10,400.00	$ 10,400.08
	Weekly	$ 600.00	$ 1,200.00	$ 1,800.00	$ 2,400.00	$ 2,400.02
5	Annual (up to)	**$ 36,580.00**	**$ 73,160.00**	**$ 109,740.00**	**$ 146,320.00**	**$ 146,321.00**
	Monthly	$ 3,048.33	$ 6,096.67	$ 9,145.00	$ 12,193.33	$ 12,193.42
	Weekly	$ 703.46	$ 1,406.92	$ 2,110.38	$ 2,813.85	$ 2,813.87
6	Annual (up to)	**$ 41,960.00**	**$ 83,920.00**	**$ 125,880.00**	**$ 167,840.00**	**$ 167,841.00**
	Monthly	$ 3,496.67	$ 6,993.33	$ 10,490.00	$ 13,986.67	$ 13,986.75
	Weekly	$ 806.92	$ 1,613.85	$ 2,420.77	$ 3,227.69	$ 3,227.71
7	Annual (up to)	**$ 47,340.00**	**$ 94,680.00**	**$ 142,020.00**	**$ 189,360.00**	**$ 189,361.00**
	Monthly	$ 3,945.00	$ 7,890.00	$ 11,835.00	$ 15,780.00	$ 15,780.08
	Weekly	$ 910.38	$ 1,820.77	$ 2,731.15	$ 3,641.54	$ 3,641.56
8	Annual (up to)	**$ 52,720.00**	**$ 105,440.00**	**$ 158,160.00**	**$ 210,880.00**	**$ 210,881.00**
	Monthly	$ 4,393.33	$ 8,786.67	$ 13,180.00	$ 17,573.33	$ 17,573.42
	Weekly	$ 1,013.85	$ 2,027.69	$ 3,041.54	$ 4,055.38	$ 4,055.40
Each Additional Person	Annual (up to)	**$ 5,380.00**	**$ 10,760.00**	**$ 16,140.00**	**$ 21,520.00**	**$ 21,520.00**
	Monthly	$ 448.33	$ 896.67	$ 1,345.00	$ 1,793.33	$ 1,793.33
	Weekly	$ 103.46	$ 206.92	$ 310.38	$ 413.85	$ 413.85

Updated using Federal Poverty Guidelines for 2024:https://www.federalregister.gov/documents/2024/01/17/2024-00796/annual-update-of-the-hhs-poverty-guidelines

Sliding Fee Discount Application

It is the policy of CNS Healthcare to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Name of Head of Household			Place of Employment	
Street	City	State	Zip	Phone

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print)

Signature

Date

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		