ATTACHMENT B

Behavioral Health Network
SLIDING FEE CONTRACT

Name: _____ Carelogic ID: _____

Date: _____

WORKSHEET TO DETERMINE HOUSEHOLD INCOME FOR SLIDING FEE

HOUSEHOLD MEMBERS			PERSONAL INCOME			
Name	**DOB**	**Relationship**	**Salary & Wages**	**SSI/SSDI/ TANF**	**Other Income**	**TOTAL INCOME**
1. _____	_____	____SELF____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____	_____

TOTAL HOUSEHOLD INCOME **$**_____ **$**_____ **$**_____ **$**_____

$(_____**)**

Comments:

_____

_____

Total number of household members used to determine sliding fee_____

VERIFICATION OF INSURANCE AND INCOME STATUS

(Please circle one)

Y / N I am employed full time.

Y / N I am employed part time.

Y / N I am currently unemployed and have no source of income.

Y / N I am not currently covered by any health care insurance policy that would cover these services.

Y / N I did not file an income tax return for the most recent year in which one was due.

Y / N I am unable to provide any verification to this agency for the following reason:

_____.

- I agree to notify the Behavioral Health Network, Inc. in the event my financial or insurance circumstances change.

_____ _____/_____/_____
Person Served Signature Date

Based upon the income information that I have provided to this agency, the following fee for each visit has been set for me. I understand and accept that it is my responsibility to pay the fee at the time of each session. I understand that in order to qualify for this reduced fee which is provided at least in part through funds from the Department of Public Health, I must submit the agreed upon proof of income to this agency. In the event that I do not submit acceptable proof of income to this agency, I may be held liable for the full cost of services provided.

$_____ per Intake session $_____ per Individual session

$_____ per Group session $_____ per Intensive Outpatient session

_____ _____/_____/_____
Person Served Signature Date

_____ _____/_____/_____
Witness Date

Slidingfee.doc
Revised 5/22/17

ATTACHMENT C

Behavioral Health Network Sliding Fee Financial Agreement

PAYMENT GUARANTEE

In consideration of the services rendered and to be rendered to the named person served by BEHAVIORAL HEALTH NETWORK, INC. ("BHN"), I expressly understand that I am responsible for payment of BHN fees based upon the agreed to sliding fee scale (attached) and agree to pay in full at time of service delivery using cash, check, money orders or credit card. _____ (Initial)

CHANGE IN STATUS

I understand that it is my obligation to notify BHN if a change in status for the person served occurs during the delivery of care. Status changes include but are not limited to insurance coverage activation, residency change outside Massachusetts, change in income, change in family size, etc. I understand that I must provide accurate information and documentation of income and family size any time BHN requests such information. I understand that I am eligible for the sliding fee only on condition that I make payments at time of service and failure to be current may jeopardize eligibility. _____ (Initial)

CLIENT RESPONSIBILITY

I understand that it is my responsibility to provide BHN with complete and accurate insurance information when it is obtained. To best serve me and my health needs, I must always provide a current copy of my card to BHN for my record. I understand that in order for BHN to set realistic treatment goals and priorities, it is important that they have current insurance information to evaluate what resources I have available to pay for my treatment. I understand that BHN will make a best effort to inform me of the anticipated fees involved as soon as this can be reasonably determined. I understand that BHN cannot guarantee my coverage and that I am ultimately responsible for payment of services rendered._____ (Initial)

CANCELLATION POLICY

I understand that BHN respectfully requests a 24-hour notice of cancellation. I understand that if the person served has an emergency and cannot provide a 24-hour notice of cancellation, BHN must be notified as soon as possible. _____ (Initial)

I have read and understand the preceding information.

X_____
Name of Person Served (please print)

X_____
Signature of Person Served or person responsible for Person Served Date

X_____
Name of Person Responsible (please print)