McGuire Therapeutic Services

PLEASE RETURN APPLICATION IMMEDIATELY
TO ENSURE ACCURATE PROCESSING OF YOUR ACCOUNT

APPLICATION FOR SLIDING FEE SCALE

FOR OFFICE USE ONLY

Verify SS# on Maryland Medicaid EVS Website (if applicable) (Initial)

Not Eligible at Time of Service - Print Out Sheet & Attach _____ (Initial)

" **PLEASE PRINT** "

Date:__}___} _Patient's SSN / ITIN #: _____

Patient's Name: _____*Patient's Date of Birth:__/___}___*

Responsible Party/ Spouse Name: _____

Responsible Party/ Spouse Date of Birth:___/__/ ___

Responsible Party/ Spouse Social Security#: _____

*Street Address:*_____

City: _____*State:* _____*Zip Code:* _____*Phone:* _____

Do you, or the patient you represent, have medical insurance? ☐ *Yes* ☐ *No*

If YES, please provide your insurance card to the front desk representative.

Have you applied for Medical Assistance? ☐ *Yes* ☐ *No*

If eligible, please provide Medical Assistance Member#: _____

Are you a Maryland resident? ☐ *Yes* ☐ *No*

IF YOU DO NOT HAVE INSURANCE, PLEASE ASK FOR ASSISTANCE FROM THE APPLICATION COUNSELOR.

Have you applied for MCHP (Maryland Children's Health Program)? ☐ *Yes* ☐ *No*

Do you have a State of Maryland pharmacy card? ☐ *Yes* ☐ *No*

If yes, list identification#:

Eligibility for Mcguire Therapeutic Services' sliding fee scale financial assistance is based on income levels relative to the federal poverty guidelines published annually and the number of individuals living in your household. Certain sources of income are excluded from the calculation of household income (see below).

Please list the following MEMBERS of your household (self, spouse, significant other, and children, including step-children and legally adopted children, up to 18 years of age) and list ALL income earned by the listed members.

(Proof of income for all listed must be returned within 7 days or at next scheduled appointment, whichever comes first.)

Name	Relationship	DOB	Social Security (if Applicable)	Yearly Income

Comments:

_____

_____

If no members of your household earn income used to calculate eligibility for the sliding fee scale, please check the box below and the appropriate box within the Means of Support.

☐ I attest that all members of my household have **NO INCOME.**

Please note that all applications must be updated annually.

Documents Accepted as Proof of Income (POI):

- ☐ Current Pay Stubs-within 90 days (minimum: 1 pay stub)
- ☐ W2 Tax Form
- ☐ Tax Return Form #1040 (Line 9) (total income)
- ☐ Tax Return Form #1040SR (Line 9) (total income)
- ☐ Social Security (Staff: READ Contents of Letter)
- ☐ Unemployment (for 6 months)
- ☐ Letter from Employer

If You Attest to No Income, Please Check Means of Support:

- ☐ Disability
- ☐ Child Support
- ☐ Workers Compensation
- ☐ Temporary Cash Assistance
- ☐ 551 (Supplemental Security Income)
- ☐ Social Security Disability
- ☐ Live with other family member
- ☐ Other _____

Please answer the following survey questions:

McGuire Therapeutic Services' nominal fee for medical and behavioral health services is $85 and $125. Do you feel this charge is (check one): ☐ Fair/Adequate ☐ Too Expensive ☐ Would Prevent Me From Seeking Care
If you checked "Too Expensive or Would Prevent Me From Seeking Care" please provide your opinion of an appropriate fee: $

I certify under penalties of perjury, that the above statements are true, accurate and complete to the best of my knowledge and belief.

_____ _____

Applicant / Guarantor's Signature Date

FOR OFFICE USE ONLY

Has patient been referred to the Certified Application Counselor (CAC)? ☐ Yes ☐ No

Please write name of CAC: _____

Monthly: _____ (# in Household) _____ (Gross) **X** 12 (12 mo.) = _____ (Total Amount)

Weekly: _____ (# in Household) _____ (Gross) **X** 52 (52 weeks) = (Total Amount)

Bi-Weekly: _____ (# in Household) _____ (Gross) **X** 26 (26 weeks) = (Total Amount)

Annual: _____ (# in Household) _____ (Gross) **X** 1 (1 year) = _____ (Total Amount)

Qualifying Level: ☐ Nominal ☐ Level I ☐ Level II ☐ Level III ☐Not eligible

Medical Receptionist Printed Name: _____ Site: _____

Medical Receptionist Signature: _____ Date: _____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing McGuire Therapeutic Services (MTS) for your mental health needs. We are honored by your choice and we are committed to providing you with the highest quality healthcare. We ask that you read the following information to understand our policy regarding self-pay patients and the sliding fee scale discount that we offer, as follows:

Please be aware that McGuire Therapeutic Services expects the information you provide to apply for the sliding fee discount to be true, complete and accurate. The information that you are providing concerning the size of your family (i.e., as family composition would be reported on an IRS tax return) and your family's gross annual income, from all sources (e.g., earned income, Social Security benefits, SSI, unemployment benefits, etc.), must be correct to the best of your knowledge. MTS may request additional information, if needed, to determine eligibility. You are also responsible for promptly notifying MTS of changes in insurance, family income or size.

MTS relies on the information concerning your financial situation and your means and ability to pay in order to determine the applicable discount for services rendered to you.

Therefore, if MTS has reason to suspect that the infonnation you have given is untrue incomplete or inaccurate or that you have not properly reported changes, MTS may initiate a review of your financial status. If you are found to have provided untrue information, you may be billed for any discounts you have received and possibly forfeit eligibility for the sliding fee program.

Applicant Signature _____ Date _____

Applicant Printed name _____ Date of Birth _____