South Central Human Relations Center
Guidelines for Sliding Fee Application

1. All household income must be provided with proofs.

2. Individuals must apply for MA and/or MNSure first. Proof of denial must be included with the application.

3. Typically, individuals with commercial insurance will not qualify. If there are extenuating circumstances, please give details and understand proof of statements may be requested.

4. Sliding Scale is offered for outpatient and psychiatry needs. The Sliding Scale is not available for groups, such as DBT or Domestic Violence Men's Group.

5. A new application must be filled out every 12 months.

Please route the attached application with all proofs to SCHRC's Patient Account Rep. A decision will be made within 3 business days.

2021 Annual Income Thresholds by Sliding Fee Discount

FPG%		200%	250%	300%	350%	400%
Client Pays	0%	10%	25%	50%	75%	100%
1	$12,760	$25,520	$31,900	$38,280	$44,660	$51,040
2	$17,240	$34,480	$43,100	$51,720	$60,340	$68,960
3	$21,720	$43,440	$54,300	$65,160	$76,020	$86,880
4	$26,200	$52,400	$65,500	$78,600	$91,700	$104,800
5	$30,680	$61,360	$76,700	$92,040	$107,380	$122,720
6	$35,160	$70,320	$87,900	$105,480	$123,060	$140,640
7	$39,640	$79,280	$99,100	$118,920	$138,740	$158,560
8	$44,120	$88,240	$110,300	$132,360	$154,420	$176,480

Add $4,480 for each additional person

SOUTH CENTRAL HUMAN RELATIONS CENTER

Providing Direction for Life's Problems Since 1964

Sliding Fee Discount Application

Discounts may be offered to residents of Dodge, Waseca and Steele counties and are based on family size and income. Please complete the following information to determine if you or members of your family are eligible for the discount.

This form must be completed every 12 months or if your financial situation changes.

Name: ____________________________________ Phone Number: ___________________________ Account: ___________

Address:____

Please list spouse and dependents under the age of 18.

Spouse: __________________________ DOB: ____________ Dependent: ________________________ DOB: _____________

Dependent: _______________________ DOB: ____________ Dependent: ________________________ DOB: ____________

Dependent: _______________________ DOB: ____________ Dependent: ________________________ DOB: ____________

Dependent: _______________________ DOB: ____________ Dependent: ________________________ DOB: ____________

Annual Household Income – A copy of a tax return, paystubs or other information verifying income is required before discount is approved.

Gross Wages, salaries, tips, etc. $ ________________________

Income from business, self-employment, dependents, unemployment compensation, worker's compensation, Social Security Income, Supplemental Security Income, public assistance, veteran's payments, survivor's benefits, pensions retirement income, interest, dividends, royalties, income from estates, trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources. $________________________

Total Income $________________________

Please include copies of your insurance card or denial of MA or MN Care.

Insurance Company Name: ____ Effective Date: _________________________

Group Number: _______________________________________ Insurance Number: ______________________________

Monthly Premium: _________________________ Yearly Deductible: ______________________

If no insurance, have you applied for Medical Assistance or MN Care? _____ Yes _____No

Results of the application:

____

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Additional information you would like considered:

For office use:

Approved: _____________ Denied: ____________

Approved discount: %____________ Services discount approved for: ____

Approved By:____ Date:___________________________