SLIDING SCALE FEE SCHEDULE

ROBERTA'S HOUSE POLICY REGARDING FEE FOR SERVICE CHARGES

Sliding Scale Fee Schedule

Roberta's House Behavioral Health Program provides fee for service individual, family, couples, and group counseling services. Clients who have household incomes at or below 300 percent of the Federal Poverty Level are eligible to receive services on a sliding scale.

Any self-pay client with a household income of at least 100 percent of the Federal Poverty Guidelines, but less than or equal to 300 percent of the federal poverty guidelines are at a reduced rate.

100%	$5 per session
150%	$10
200%	$15
300%	$20

Each sliding fee scale lasts for one year. Every year, thereafter, you will need to re-apply.

Household income is the total amount earned yearly (also called: annually) by those in your household. Household income counts every person of any age who lives in your household.

Household members include:

- Roberta's House Client,
- Patient's legal spouse, if any,
- and any legal dependents – children, foster kids, adults legally in the patient's care.

For Clients under 18, the household members include:

- the Client,
- their legal guardian or guardians,
- and any legal dependents of their legal guardian(s).
- Anyone in your household who is 18 or older must provide proof of income. Household members who don't earn an income will need to fill out a Verification of No Income Form instead of Proof of Income Form when applying for the sliding fee scale.

We require proof of income for every household member 18 and over.

- Without proof of income, individuals cannot be counted toward household size.
- Proof of income includes your most recent paystubs, tax forms, Social Security award letters, or benefit letters from Department of Social Services. They must be from the most recent month or year that the income was received.

A chart of the Federal Poverty Levels is below.

2024 Federal Poverty Guidelines: 48 Contiguous States (all states except Alaska & Hawaii)

Persons in family/household	**Poverty guideline (annual income)**				
	100%	150%	200%	250%	300%
1	$15,060	$22,590	$30,120	$37,650	$45,180
2	$20,440	$30,660	$40,880	$51,100	$61,320
3	$25,820	$38,730	$51,640	$64,550	$77,460
4	$31,200	$46,800	$62,400	$78,000	$93,600
5	$36,580	$54,870	$73,160	$91,450	$109,740
6	$41,960	$62,940	$83,920	$104,900	$125,880
7	$47,340	$71,010	$94,680	$118,350	$142,020
8	$52,720	$79,080	$105,440	$131,800	$158,160

Guidelines for prior years, from 1982 to the present, are available online on HHS's website.

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Zero Income Statement

Name: _____ Address: _____

This is a self-declaration statement to certify that I am not receiving income from any source whatsoever. The sources include but are not limited to:

___ I am not employed through any private or public employer.

___ I am not receiving unemployment compensation benefits.

___ I am not receiving Social Security, SSI, Disability benefits, Workmen's Compensation, Veteran's Pension or any type of annuity benefits.

___ I am not receiving Public Assistance (PA).

___ I am not receiving income from any source (such as interest from bank accounts or rents from rental property).

___ I am on maternity leave without pay.

___ I do not receive alimony or child support.

___ Other _____

___ I understand that I must complete a new Verification of No Income Form annually.

I have read and understood the above statements and understand that any misrepresentation of the above will result in termination of the sliding scale fee agreement.

Signature Date

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ROBERTA'S HOUSE POLICY REGARDING FEE FOR SERVICE CHARGES
Application For Sliding Fee Scale

Date: _____ Patient's SSN #: _____

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 client you represent, have medical/dental 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

Do you have insurance? _____Yes _____No

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

Eligibility for Roberta's House Inc. 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.

Please list the following MEMBERS of your household (self, spouse, significant other, and children, including stepchildren 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	Date of Birth	Annual Income
	SELF		

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):

____ Pay Stubs (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
____ SSI (Supplemental Security Income)
____ Social Security Disability
____ Other

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

Monthly: _____ # in Household _____Gross X 12 mo. = _____Total Amount

Weekly: _____# in Household _____Gross X 52 weeks = _____Total Amount

Bi-Weekly: _____# in Household _____Gross X 26 weeks= _____ Total Amount

Qualifying Level: _____

Printed Name: _____
Staff Signature: _____
Date: _____