Northwest Neurobehavioral Health, LLC
Discount Fee Policy & Application

It is the policy of Northwest Neurobehavioral Health, LLC (NNH) to provide essential mental health services regardless of the client's inability to pay. Discounts are offered based upon household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for four (4) months, after which the client must reapply. If you are approved for a discount and are eligible for insurance benefits, you are unable to bill your insurance company. Your insurance will NOT be billed.

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 mental health services received at this clinic, but not those services for which you may be referred. Please notify us immediately if your financial situation changes. Payment for discounted services is expected at the time of service.

Patient's Name: ____________________ Number of related persons living in your household: _____

Total household income: Complete one column

Household Member	Household Income **Annual**	Household Income **Monthly**	Household Income **Bi-Weekly**
Self			
Spouse			
Dependent children under age 18			
TOTAL			

Note: Include income from all sources including gross wages, tips, social security, disability, Supplemental Security Income, survivor benefits, retirement income, interest, dividends, rents, income from estates, trustees, educational assistance, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and Workers' Compensation (Housing subsidies and Food stamps do not apply)

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income will be required before a discount is approved. If not earning an income, please provide a brief statement explaining how living expenses are being covered.

___________________________________ ______________________________ ___________

Name of responsible party (please print) **Signature** **Date**

Office Use Only

Patient Name: ____________________________________ Approved by: ________________

Discount: ___________ Patient Responsibility: ____________ Write Off Amt: _____________

Effective Dates:_______________________ Service(s): ________________________________

Provider: ______________________ Accepted ___ Denied ___ Referred to: _______________

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