DEEPER FOCUS LLC

Sliding-Scale Payment Assistance Application

Confidential – Financial Assistance Request

Purpose

Deeper Focus LLC is committed to providing accessible, compassionate, and affordable behavioral health services. Our Sliding-Scale Payment Assistance Program offers reduced fees to eligible individuals based on household income, household size, financial circumstances, and demonstrated financial hardship.

Approval is based on available program resources and individualized financial review. Clients will receive a written decision identifying any approved reduced fees.

Section A: Client Information

Client Full Name: _____

Date of Birth: _____

Parent/Guardian (if applicable): _____

Phone Number: _____

Email Address: _____

Date of Application: _____

Preferred Method of Contact: □ Phone □ Email □ Mail

Section B: Insurance Information

Current Insurance Status:

□ I do not have health insurance.

□ I have private health insurance but am requesting self-pay services.

□ I recently lost my health insurance coverage.

□ I have applied for Medicaid or other health insurance and am awaiting a decision.

□ I have Medicare or Medicaid coverage.

□ Other: _____

Clients enrolled in Medicare, Medicaid, or another federally funded insurance program will receive a separate eligibility and billing review before any discounted payment arrangement is offered.

Section C: Household and Income Information

Number of People in Household: _____

Number of Dependents: _____

Total Gross Household Monthly Income: $_____

Estimated Gross Annual Household Income: $_____

Primary Source(s) of Income (check all that apply):

□ Full-time employment

□ Part-time employment

□ Self-employment

□ Social Security / Disability

□ Unemployment benefits

□ Retirement / Pension

□ Financial support from family or others

□ No current income

□ Other: _____

Section D: Financial Hardship Assessment

Are you currently experiencing financial hardship?

□ Yes □ No

Please select any circumstances affecting your ability to pay:

□ Unemployment or reduced working hours

□ Housing instability or homelessness

□ High medical expenses

□ Disability-related financial hardship

□ Unexpected family emergency

□ Loss of household income

□ Significant caregiving expenses

□ Recent separation, divorce, or death in family

□ Other: _____

Optional: Briefly explain any circumstances you would like Deeper Focus LLC to consider when reviewing your application:

Section E: Financial Documentation

To support this request, applicants may provide one or more of the following:

□ Two recent pay stubs

□ Most recent tax return or W-2

□ Social Security / Disability income statement

□ Unemployment benefit documentation

□ Written statement of no income

□ Other proof of income or financial hardship

□ Documentation unavailable; alternative verification requested

Please do not submit bank account numbers, Social Security numbers, or unrelated medical records.

Section F: Requested Financial Assistance

Services Requested:

□ Initial Diagnostic Assessment

□ Individual Counseling

□ Family Counseling

□ Group Counseling

□ Other: _____

Amount I Believe I Can Afford Per Individual Therapy Session:

□ $50 □ $65 □ $80 □ $95 □ Standard Rate

□ Other amount requested: $_____

Anticipated Frequency:

□ Weekly

□ Biweekly

□ Monthly

□ Other: _____

Section G: Client Acknowledgment and Agreement

By signing this application, I acknowledge that:

I certify that the financial information provided is accurate to the best of my knowledge.

I understand that submitting an application does not guarantee approval.

I understand that the approved fee and effective dates will be provided in writing.

I agree to notify Deeper Focus LLC of significant changes in my insurance coverage or financial circumstances.

I understand that I am responsible for any agreed-upon fees for services received, consistent with the practice's financial policies.

My financial information will be maintained confidentially and accessed only by authorized personnel for legitimate administrative purposes.

I understand that I may request reconsideration if my financial situation changes or if my application is denied.

I understand that financial assistance decisions will not determine my clinical diagnosis or treatment recommendations.

Client/Guardian Signature: _____

Date: _____

Section H: Administrative Use Only

Application Received: _____

Reviewed By: _____

Documentation Status:

□ Complete

□ Additional information requested

□ Alternative verification accepted

Household Size: _____

Verified/Reported Annual Income: $_____

Financial Hardship Considered: □ Yes □ No

Standard Session Rate: $_____

Approved Individual Therapy Rate: $_____

Approved Other Service Rates (if applicable):

Decision:

□ Approved

□ Approved with individualized hardship exception

□ Additional documentation needed

□ Denied

Reason/Explanation:

Effective Date: _____

Expiration / Review Date: _____

Approving Administrator: _____

Signature: _____

Date: _____