Sliding Fee Scale

Type of Service	Fee – Maximum
Initial Intake	$70.00
Psychiatric Evaluation	$100.00
Medication Management	$40.00 per session
Individual Therapy (30 min session)	$45.00 per session
Individual Therapy (45 min -1 hr session)	$75.00 per session
Group Therapy	$25.00 per person
Family Therapy	$75.00 per session
Family Psychoeducation	$65.00 per session

Sliding scale fees are subject to change*

A sliding scale fee determines how much you pay for services. A scale is a chart that helps us see how much your fee should be and sliding means that fees are not the same for everyone. Life Renewal Services provides a sliding fee scale for families/clients at or below 200% FPL (Federal Poverty Level), patients above 200% must pay full charge. Families/Clients 101%-200% FPL receive a discount based on income and Patients below 100% FPL receive a 100% discount with some services requiring a nominal fee. A LRS representative will meet with you to discuss any fees concerning your treatment services here at Life Renewal Services.

Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	Discount 100%	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 15%	Discount 10%	Discount 0%
1	$15,060	$16,566	$18,072	$19,578	$21,084	$22,590	$24,096	$25,602	$27,108	$28,614	$30,120	>$30,120
2	$20,440	$22,484	$24,528	$26,572	$28,616	$30,660	$32,704	$34,748	$36,792	$38,836	$40,880	>$40,880
3	$25,820	$28,402	$30,984	$33,566	$36,148	$38,730	$41,312	$43,894	$46,476	$49,058	$51,640	>$51,640
4	$31,200	$34,320	$37,440	$40,560	$43,680	$46,800	$49,920	$53,040	$56,160	$59,280	$62,400	>$62,400
5	$36,580	$40,238	$43,896	$47,554	$51,212	$54,870	$58,528	$62,186	$65,844	$69,502	$73,160	>$73,160
6	$41,960	$46,156	$50,352	$54,548	$58,744	$62,940	$67,136	$71,332	$75,528	$79,724	$83,920	>$83,920
7	$47,340	$52,074	$56,808	$61,542	$66,276	$71,010	$75,744	$80,478	$85,212	$89,946	$94,680	>$94,680
8	$52,720	$57,992	$63,264	$68,536	$73,808	$79,080	$84,352	$89,624	$94,896	$100,168	$105,440	>$105,440
For each additional person, add	$5,380	$5,918	$6,456	$6,994	$7,532	$8,070	$8,608	$9,146	$9,684	$10,222	$10,760	>$10,760

*Based on the 2024 Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia. Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines.

Required Documentation for Discounts - Clients who decline to offer this information are ineligible for a discount.

• Documentation is required for discounts after the initial visits
• **Proof of Income** (If Employed) One of the Following:
o 1040
o W2
o 2 recent pay stubs
o Written statement by employer

• **Proof of Income** (If Unemployed) One of the Following:
o Public Assistance check stub/copy
o Social Security check stub or letter of award
o Certification Letter from Medical Assistance or Department of Social Services
o Completed zero income form
o Written statement from friend or relative with whom patient lives (if other forms not available)
o Letter of reference from a 501 (c)(3) organization, such as a church (if other forms not available)

• **Proof of Address** One of the following:
o Driver's license
o MVA ID,
o Any document (envelope) recently addressed to patient such as a utility bill
o A written statement by relative or friend with whom patient lives

• **Proof of Address** (Immigrants) One of the Following:
o Form 1551
o Form 194

NAME OF APPLICANT			PLACE OF EMPLOYMENT	
NAME OF CLIENT/PATIENT			HAVE YOU APPLIED TO MEDICAL ASSISTANCE: ☐YES ☐NO	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

NOTE: Two of the following are required to verify income:

- ☐ Most recent paycheck stub
- ☐ W-2 form
- ☐ Last income tax return
- ☐ Employer verification letter

Or

- ☐ Unemployment/Social Security check stub

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents Unemployment compensation,				
workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income Interest, dividends, rents, royalties, income from estates,				
trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

My signature below indicates that I certify that the family size and income information shown above is correct and I authorize Complete Wellness to access information that will confirm the income disclosed on this application.

Applicant Name (Print)

Applicant Signature ____

Date

Office Use Only

Patient Name:	
Date Approved:	

Approved Discount:		Approved by:	
Approved Discount:		Approved by:	
Approved Fee:		Approved by:	
Approved Fee:		Approved by:	

Verification Checklist	Select one in each group
Identification/Address:	☐ Driver's license ☐ Utility bill ☐ Employment ID ☐ Other
Income:	☐ Prior year tax return ☐ Most recent pay stub ☐ Other
Insurance:	☐ Insurance Card