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**CBF Sliding Scale Program**

Creating Brighter Futures sliding scale is designed for all who are unable to pay for their services. Creating Brighter Futures will base program eligibility on a persons ability to pay and will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. The Federal Poverty Guidelines (<http://aspe.hhs.gov/poverty>) are used in creating and annually updating the sliding fee schedule to determine eligibility. In order to participate in the CBF sliding scale program, eligibility must be completed prior to the start of services or following a significant change in financial situation.

These guidelines are to be followed in providing the Sliding Scale discount program.

1. **Notification:** Creating Brighter Futures will notify patients of the Sliding Scale Program by:
   1. An explanation of our Sliding Scale Program and our application form are available on our website.
2. **Request for Discount:** Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. Discounted services would apply effective the date of application approval going forward. Information and forms can be obtained from our Human Resource Coordinator.
3. **Administration**: The Sliding Scale Program procedure will be administered through the Human Resource Coordinator or his/her designee. Information about the Sliding Scale Program policy and procedures will be provided, and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who see and/or are provided charitable services.
4. **Alternative Payment Sources**: All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs.
5. **Application**: The patient/responsible party must complete the Sliding Scale program application in its entirety. By signing the Sliding Scale Program application, persons authorize Creating Brighter Futures access in confirming income as disclosed on the application form. Providing false information on a Sliding Scale Program application will result in all Sliding Scale Program discounts being revoked and the full balance of the account(s) restored and payable immediately.
6. **Initial** **Application**: If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supple the necessary information without having the date on their application adjusted. If a patient does not provide the requested information within the two-week time period, their application will be re-dated to the date on which they supply th requested information. Any accounts turned over for collection as a result of the patients delay in providing information will not be considered or the Sliding Scale program.
7. **Renewal** **Applications**: A patient who receives discounted services under this policy is require to submit an updated application every 12 months or if their financial situation changes. Failure to meet the annual financial information requirement may result in the patient no longer being eligible for the Sliding Scale program. If a patient is delinquent in meeting the updated annual application requirement, Creating Brighter Futures will mail the patient a notice they are being terminated from the Sliding Scale Program unless they submit the required financial information within the time frame (10 business days) noted in the letter. If a patient does not submit the renewal information, they are no longer eligible for the discounted services per the date in the notice letter.
8. **Discounts**: Discounts will be based on income and family size only. Creating Brighter Futures defines a family as head of household, spouse, and dependent children.
9. **Income** **includes**: earnings, unemployment compensation, workers compensation, social security, supplemental security income, public assistance, veterans payment, 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. Noncash benefits (such as food stamps and housing subsidies) do not count.
10. **Requirements**: Applicants must provide the following: prior year W-2, two most recent bank statements and two most recent pay stubs. Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self-declaration of income may be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why he/she is unable to provide independent verification. This statement will be reviewed and final determination as to the sliding scale percentage will be made. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.
11. **Updates**: The sliding scale will be updated during the first quarter of every calendar year with the latest federal poverty guidelines, <https://aspe.hhs.gov/poverty>.
12. **Notice**: The sliding scale program determination will be provided to the applicant(s) in writing and will include the percentage of the sliding scale program write off, or, if applicable, the reason for denial. If the application is approved for less than 100% discount of denied, the patient and/or responsible party must immediately establish payment arrangements with Creating Brighter Futures. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last sliding scale discount program application.
13. **Refusal** **to** **Pay**: If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations.

If the patient does not make effort to pay or fails to respond within 14 days, this constitutes refusal to pay. At this point in time, Creating Brighter Futures can explore options not limited to, but including offering the patient a payment plan, waiving of charges, or referring for patient collection’s efforts.

1. **Storage** **of** **Information**: Information related to sliding scale discount program decisions will be maintained and preserved in a centralized confidential file.

**Sliding Scale Discount Application**

Discounts are offered based on family size and annual income. Please complete the following information and return to the Human Resource Coordinator to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at Creating Brighter Futures. This form must be completed every 12 months if you financial situation changes.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Place of Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (City, State, Zip):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list spouse and dependents under age 18**

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Date of Birth** |
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**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: |  |  |  |  |

**NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved**.

I certify that the family size and income information shown above is correct.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Office Use Only***

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved Discount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Approved:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Verification Checklist | Yes | No |
| Identification/Address: Driver’s license, utility bill, employment ID, or other |  |  |
| Income: Prior years tax return, three most recent pay stubs or other. |  |  |
| Insurance: Insurance cards |  |  |