Acknowledgement and Receipt: Sliding Fee Discount Program

My signature below confirms the following to be true:

I have been provided with a copy, read and understand the Clarity Sliding Fee Discount Program Policy.

_____
Name (Printed)

_____ _____
Signature Date

Sliding Fee Discount Application

It is the policy of Clarity Wellness Community to provide essential services regardless of your ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount.

This discount will apply to all services received at this program. This form must be completed every 12 months or if your financial situation changes.

Name of head of Household: _____

Home Address: _____
Street City State Zip

Home Phone Number: _____

Cell Phone Number: _____

Place of Employment: _____

Please list all household members, including those under age 18:

	Name	DOB
Self		
Other		
Other		
Other		
Other		
Other		
Other		
Other		

Source of Income	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from Business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; 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.

Print Name: _____

Signature: _____

Date: _____

Clarity Staff Use Only

Approved Discount: _____

Approved By: _____

Date Approved: _____

***Please attach copies of income sources.**

Payment Agreement

Name:

If Minor, Responsible Party's Name:

Address:

City, State, and Zip:

Account Number:

Date:

Total Amount Due:

This document is to act as a set agreement for an approved payment agreement based upon policy set by Clarity Wellness Community.

The responsible party listed above will agree to this payment agreement as stated below for the outstanding account balance. Should the responsible party deviate from the agreed plan at any time (including but not limited to missed payments, delinquent payments, declined payments or payments not made in full), Clarity Wellness Community reserves the right to charge interest, penalties, or consider the account's delinquency at any time and will forward the outstanding balance to an outside collection agency.

The responsible party agrees to pay Clarity Wellness Community $_____ per month starting _____. This amount will be collected on the _____ of each month until the balance is $0.00.

Please sign and return the original document. The signature of this document denotes all parties agreed to the terms of this agreement.

Responsible Party Signature: _____
Date

Clarity Wellness Representative: _____
Date

Sliding Fee Discount Schedule

Total Household Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level	At or Below 100%	125%	150%	175%	200%	Above 200%
Charge						
Family Size	**Nominal Fee ($5)**	**20% Pay**	**40% Pay**	**60% Pay**	**80% Pay**	**100% Pay**
1	0-$14,580	$14,581-$18,225	$18,226-$21,870	$21,871-$25,515	$25,516-$29,160	$29,161+
2	0-$19,720	$19,721-$24,650	$24,651-$29,580	$29,581-$34,510	$34,511-$39,440	$39,441+
3	0-$24,860	$24,861-$31,075	$31,076-$37,290	$37,291-$43,505	$43,506-$49,720	$49,721+
4	0-$30,000	$30,001-$37,500	$37,501-$45,000	$45,001-$52.500	$52,501-$60,000	$60,001+
5	0-$35,140	$35,141-$43,925	$43,926-$52,710	$52,711-$61,495	$61,496-$70,280	$70,281+
6	0-$40,280	$40,281-$50,350	$50,351-$60,420	$60,421-$70,490	$70,491-$80,560	$80,561+
7	0-$45,420	$45,421-$56,775	$56,776-$68,130	$68,131-$79,485	$79,486-$90,840	$90,841+
8	0-$50,560	$50,561-$63,200	$63,201-$75,840	$75,841-$88,480	$88,481-$101,120	$101,121+
For each additional person add	$5,5140	$7,710	$7,080	$8,995	$10,280	$11,565

* Based on 2023 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)