COMTREA
HEALTH CENTER

COMMUNITY TREATMENT, INC.

277 E MAIN STREET FESTUS, MO. 63028
Phone: (636) 931-2700 FAX: (636) 931-5304

Community Treatment, Inc. receives a grant from the federal government; this grant enables patients without medical insurance to apply for a discount.
Patients who qualify for this grant are eligible for a discount on their medical cost, with the balance being paid by the federal government. Please complete the attached form and return to the address listed above. Please contact the office for approval determination.

We require the application for sliding fee to be completed, signed, and dated with accurate proof of total household income as required by federal regulations. A "household" is defined as father, mother, guardian and children under 18yrs of age or dependents under guardianship.

Acceptable income documents

Provide all of the following that applies to your household.

☐ Previous year federal tax returns or W9 forms

☐ Last **2 paycheck stubs** for **each** adult working **in the household**

☐ A statement from your employer (signed, dated on company letterhead) stating rate of pay, average number of hours worked weekly, and including your hire date

☐ Quarterly tax statement if member of your household are self employed

☐ Unemployment benefit letter

☐ Benefit letter from Social Security showing your monthly payment (a letter for each person who receives these benefits in your household)

☐ Documentation of alimony (letter from divorce paperwork, ect.)

☐ Copy of pension/retirement benefits

☐ **Full time unemployed students**: Provide us with your payment history for the current semester (this can be obtained from the cashier's office)

☐ State support: Food stamps, we require the packet you received with your approval, this includes start and stop dates, and **Food Stamp Budget Summary page**

If you receive none of the above we require you to apply for assistance from the state level 1st. Contact the **Division of Family Support** at **(855) 373-4636**. You must apply for medical assistance, and food stamp assistance. **If denied bring us the denial packet, including the food stamp budget summary page, for possible Federal assistance.**

Community Treatment, Inc.

Application for Sliding Fee Program

_____ DOB: _____SSN_____
Applicant Name (please print)

_____
Address (please print) City State Zip

Phone #_____ Additional Phone#_____

Under 18 years, parent/guardian name _____ Phone_____

Reason for Applying

- ☐ I have no medical/mental health insurance
- ☐ I have medical/mental health insurance with a deductible over $1000/per year _____
- ☐ I have medical/mental health insurance that only has limited coverage_____ (i.e. covers contraception only).
- ☐ I have no dental insurance
- ☐ I have dental insurance with a deductible over $1500/per year____
- ☐ I have dental insurance that only has limited coverage_____(i.e. covers cleaning only)

Total number in household _____ **Adults _____ Children _____ (under age 18)**
Dependents under guardianship_____

Names of household members:

NAME	DATE OF BIRTH	RELATIONSHIP	EXISTING PATIENT

Have you applied for Medicaid? ☐ **YES** ☐ **NO** Reason for Denial_____
Does the Patient currently reside in a COMTREA facility? _____
Is the Patient participating with the Supportive Community Living Program through COMTREA?_____

Sources of Income for **HOUSEHOLD (*Check YES or NO*)**

Employed? ☐**YES** ☐ **NO** *Please provide 2 current pay-stubs for **EACH** person in household and **EACH** Job.*
Hire Date_____ How often are you paid? Weekly Biweekly Monthly

Self Employed? ☐ **YES** ☐ **NO** *Please provide net receipts or tax return.*

Social Security? ☐ **YES** ☐ **NO** *Please provide Social Security Award letter.*

Alimony ☐ **YES** ☐ **NO** *Please provide court order print-out.*

Retirement/Pension? ☐ **YES** ☐ **NO** *Please provide documentation.*

Unemployment Income? ☐ **YES** ☐ **NO** *Please provide print out of Unemployment Benefit letter.*

***If you have none of the sources of income listed above, please provide your Food Stamp Budget Summary Letter to verify income for our grant.**

By signing this form, I verify that the above information is true to the best of my knowledge. I agree to pay my Sliding Fee discount fee at the time of each visit. I also understand that referral services outside of Community Treatment, Inc. are not covered by my Sliding Fee Discount, and if Quest Lab services are used during my visit that Quest will bill me separate from Community Treatment, Inc. for those services. If my income changes in anyway, I will notify Community Treatment, Inc. of these changes and provide updated income documentation.

_____ _____
Signature of Applicant Date

Reserved for Community Treatment, Inc. Staff Acct/Chart#_____ ☐ BH ☐ PC ☐ OH
Qualify: ☐ Yes ☐ No Annual Household Income:_____ SF Level_____
Comments:_____
_____
Expiration Date_____Processing Employee_____