

Medicaid Number: _____
 Client Name: _____

Record Number: _____
 Date of Birth: _____

SERVICE FEES AND SLIDING FEE SCHEDULE

DAYMARK Recovery Services, Inc. sets our service fees and sliding fee scale based on current year adjusted federal poverty guidelines. It is our goal to provide quality and affordable healthcare to all the communities we serve. If your financial status changes during the course of your treatment, please notify Administrative Staff and they will assist you to update your paperwork.

If you do not have health insurance, you will need to provide documentation of proof of income. This will allow us to reduce your out of pocket cost for treatment services provided at Daymark.

Please make an effort to provide the following documents as soon as possible to ensure we can minimize your out of pocket cost for treatment. We appreciate you providing documents needed in a timely fashion and offer a variety of ways this can be done:

- Please provide documentation needed to center staff at your next visit.

STAFF: PLEASE COMPLETE ALL SECTIONS BELOW

Please check ONE of the following as proof of income:	
<input type="checkbox"/>	Current Pay Stub
<input type="checkbox"/>	Most recent W2
<input type="checkbox"/>	Copy of most recent tax return

Please complete the following:	
<input type="checkbox"/>	Annual Income ÷ 12 = Monthly Income \$ _____ ÷ 12 = \$ _____ put amount in 1 st column below
<input type="checkbox"/>	Provide Monthly Income
<input type="checkbox"/>	Number of dependents in your household
<input type="checkbox"/>	Percentage to pay (based on sliding fee scale sheet)

Select income source: (Make a copy of the documentation provided)			
<input type="checkbox"/>	Disability Determination	<input type="checkbox"/>	Social Security check
<input type="checkbox"/>	Child Support	<input type="checkbox"/>	Unemployment check
<input type="checkbox"/>	I do not have any source of income	<input type="checkbox"/>	Homeless
<input type="checkbox"/>	Other – please write in source(s) below		

Additional Reminders		
<input checked="" type="checkbox"/> Copies of Insurance card/s	<input checked="" type="checkbox"/> Co-pay due at time of service	<input checked="" type="checkbox"/> Social Security Card

Failure to provide the items above by your next appointment may result in full fee charges for services rendered on that service date.

 Client Signature

 Date

 Parent/Guardian Signature

 Date