Centerstone Application for Client Assistance -- Illinois

Client Name: ___________________________________ Address: ___________________________________

Date of Birth: _________________________ City, State, and Zip: ________________________________

Client ID#:____________ Phone__________________ Gender: M F Race: _________

Household Income: __________________ Family Size: _______________

Must provide one of the following: (attach to this form)

Proof of most recent pay stubs________ Provide copy of recent federal income tax return_____

Certify that unemployed__________

Federal Poverty Guidelines

Family Size	100% FPL	101%-150% FPL	151% to 200% FPL	201%-300% FPL	301% and above FPL
1	0-15,060	$15,161-22,590	$22,591-30,120	$30,121-45,180	43,709 or above
2	0-20,440	$20,441-30,660	$30,661-40,880	$40,881-61,320	59,159 or above
3	0-25,820	$25,821-38,730	$38,731-51,640	$51,641-77,460	74,579 or above
4	0-31,200	$31,201-46,800	$46,801-62,400	$62,401-93,600	89,999 above
5	0-36,580	$36,581-54,870	$54,871-73,160	$73,161-109,740	105,419 or above
6	0-41,960	$41,961-62,940	$62,941-83,920	$83,921-125,880	120,839 or above
7	0-47,340	$47,341-71,010	$71,011-94,680	$94,681-142,020	136,259 above
8	0-52,720	$52,721-79,080	$79,081-105,440	$105,441-158,160	202,240 or above

( ) Yes ( ) No Do you have private behavioral health insurance, VA benefits, IL Medicaid /IL Medicaid Managed Care?

( ) Yes ( ) No Do you currently have Medicare Part B?

Sliding Fee Scale

Service	At or Below 100% FPL	101 to 150% FPL	151-200% FPL	201% -300% FPL	301% and above
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Intake	$20	$28	$41	$138	$193
Individual	$15	$28	$41	$100	$120
Group	$5	$9	$14	$46	$64
Family	$5	$22	$32	$108	$151
Psych Eval	$20	$32	$47	$148	$148
Med Check	$10	$15	$23	$75	$75

I want to apply for Centerstone's Client Assistance Program (sliding fee scale). I understand I will not be denied services due to the inability to pay. This discount may be extended on a monthly basis if my treatment is medically necessary and I provide Centerstone verification of my income and family size. I understand that the failure to show for an appointment without giving 24-hour notice may result in my removal from the Client Assistance Program.

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Applicant/Guarantor's Signature Date

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Approval (Onsite Clinical Manager or above) Date

Completed form send the Central Billing office team- West Frankfort.

Enrollment team scan into the chart and file paper copy in sliding scale folder.