Return, mail or fax completed form and proof of income to:

**Wellness Possebilities, Inc. fax # 1-866-256-4657**

**319 First Ave Laurel, MT 59044**  ph # 1-406-672-2693

**Wellness Possebilities, Inc.**

**Fee Scale Application for**

**Behavioral Health Services**

Wellness Possebilities, Inc. offers discounted costs for services based on your annual income when voluntary treatment or medically necessary services are sought and no third party liability resources exist. If you feel this may be of benefit to you or your family, please complete the Sliding Fee Scale program application and provide verification of income. No individual will be denied access to medically necessary behavioral health services due to sex, age, race, religion, national origin, handicap, marital status or inability to pay. All attempts to provide services based on ability to pay and cover the reasonable costs of operation will be made according to circumstances, resources and needs of the individual seeking care. Eligibility is determined based on income and household size. All information is confidential.

**Head of Household Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: (First, middle initial, Last): | | Social Security Number: | Date of birth: | County: |
| Address | | City/State/Zip: | Home Phone: | Work Phone: |
| # of people living in the home: | Marital Status:  Single  Married | | Widowed  Divorced | Separated |

**Income Information:** Please complete for all adult household members: Proof of income (income tax return, last three months of wage stubs, etc… must be provided within 30 days. Otherwise, services will be rendered at customary price.

|  |  |  |  |
| --- | --- | --- | --- |
| Employed Person | Company Name | Income (Before Taxes) | Paid how often? (Check One) |
|  |  | $ | Weekly  2 times per month  Monthly  Every 2 weeks |
|  |  | $ | Weekly  2 times per month  Monthly  Every 2 weeks |
| Other sources of income: | Alimony $ | TANF $ | Pension/Retirement $ |
| Child Support $ | Disability $ | S.S.I. $ | Social Security $ |
| Unemployment $ | G.A. $ | Leases $ | Other $ |

**Household Information: List ALL members of household, including the head of household. Use back of page to add more**

Name Date of Birth Insurance Co-pay Social Security Number IHS Eligible

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. |  |  |  |  | **Yes/No** |
| 2. |  |  |  |  | **Yes/No** |
| 3. |  |  |  |  | **Yes/No** |
| 4. |  |  |  |  | **Yes/No** |
| 5. |  |  |  |  | **Yes/No** |
| 6. |  |  |  |  | **Yes/No** |

**Are you or any other household member covered by health insurance, Medicare, Medicaid, or HMK? Yes / No**

**Office Use Only:**

Approval or Denial and Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Income Total: \_\_\_\_\_\_\_\_\_\_\_

Account Type: MH/CD/SO/CR

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

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

SFS plan covers: Ind/ Fam/ Grp

SFS costs: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

By signing below, I agree that the Wellness Possebilities, Inc. staff may contact each employer or other listed agencies to confirm my income. I will provide proof of income for the purpose of calculating my cost for care. I will be asked to reapply for the program biannually. I agree to inform Wellness Possebilities, Inc. if there are changes to my income, household size or insurance coverage. I agree to pay my copay at the time services are rendered. I understand there is a $30 charge for any appointment I do not keep or cancel 24 hours in advance. I hereby certify that the information I have provided is correct and understand I can be disqualified from the program for falsification of information I have provided.

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or Power of Attorney Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_