

HYPE COUNSELING SERVICES
SLIDING FEE DISCOUNT PROGRAM APPLICATION

5911 West Broad Street, Suite B
Richmond, Virginia 23230

The Sliding Fee Discount Program (“SFDP”) is available to eligible uninsured and self-pay patients based on household income and family size using current Federal Poverty Guidelines (“FPG”).

Completion of this application does not guarantee eligibility. Applications are reviewed in accordance with the HYPE Counseling Services Sliding Fee Discount Program Policy and current Federal Poverty Guidelines.

No patient will be denied access to medically necessary behavioral health or substance use treatment services due to inability to pay.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Home Address: _____

HOUSEHOLD INFORMATION

Total Number of People in Household: _____

Please list all household members residing within the household.

Name Relationship Age

HOUSEHOLD INCOME INFORMATION

Total Monthly Household Income: _____

Source(s) of Income:

- Employment Income
- Self-Employment Income
- Unemployment Benefits
- Disability Benefits
- Social Security Benefits
- Public Assistance
- Other: _____

Applicants are not required to separately report informal financial assistance, child support payments, or non-recurring personal support not reflected within the required income verification documents submitted with this application.

Current Federal Poverty Guidelines may be reviewed through the U.S. Department of Health and Human Services website.

[Federal Poverty Guidelines](#)

REQUIRED DOCUMENTATION

Please provide the following documentation with this application:

- Two recent pay stubs
- Prior year federal income tax return

Additional documentation may be requested if necessary to verify eligibility information.

INSURANCE INFORMATION

- Uninsured
- Self-Pay

If applicable:

Insurance Company: _____

Policy Holder Name: _____

APPLICANT CERTIFICATION

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that providing false or incomplete information may result in denial of Sliding Fee Discount Program eligibility.

I understand that eligibility determinations are based solely on household income, family size, and current Federal Poverty Guidelines.

I understand that approval under the Sliding Fee Discount Program is valid for twelve (12) months unless there is a significant change in household income or family size.

I agree to notify HYPE Counseling Services if my financial circumstances change significantly during my eligibility period.

Applicant Signature: _____

Date: _____

-----**FOR OFFICE USE ONLY**-----

Date Application Received: _____

Documentation Complete: Yes No

Federal Poverty Guideline Tier Determination:

- Tier 1 (0%–100% FPG)
- Tier 2 (101%–150% FPG)
- Tier 3 (151%–200% FPG)

Approved By: _____

Approval Date: _____

Eligibility Expiration Date: _____