OSIKA & SCARANO

PSYCHOLOGICAL SERVICES, P.C.

Five Pine Street
Glens Falls, NY 12801

8 Williams Street
Elizabethtown, NY 12932

400 Rella Blvd. Suite #165
Suffern, NY 10901

Thomas S. Osika, Ph.D. Gina Scarano-Osika, Ph.D.
Tacey Shannon, LMSW Josey Kelly, LMSW Angela Pietrantoni, Psy.D.
Cairenn Spooner, LCSW-R Ginger Donohue, LCSW-R

Telephone (518) 745-0079 **Fax (518) 745-4291** **www.OSPsychServices.com**

Sliding Fee Scale Policy

The purpose of the Sliding Fee Program is to provide financial assistance to eligible individuals and families who seek care at Osika & Scarano Psychological Services. This would include, but is not limited to, those patients with a very high co-payment, a deductible, or those that have no insurance. The sliding fee scale is available to patients seen at either the Glens Falls or the Elizabethtown offices. Packets are available for pick up in any of our patient waiting areas.

Upon calling to schedule your first appointment, please ask the phone intake worker to send you the informational packet about our sliding fee scale. Please complete the application printed on page 4, and return it to us at Osika & Scarano, 5 Pine St, Glens Falls, NY 12801.

Please be advised that if six months of non-payment occurs on any account, collection procedures will begin, even if the patient account was accepted into the Sliding Fee Program. After six months of non-payment, a $50 processing fee and 18% APR will be added to the account balance and a collection agency will be notified to begin collection activity on your account.

Never is a patient in collections denied services.

Instructions for completing application:

1. **Please print** and complete all sections. Remember to attach all proof of income or the application will be returned to you. This may delay our ability to provide you with assistance.
2. If you or any other adults in your household are not employed, each must provide a written statement which includes the following: it must state that you are not employed, have no income AND describe how you are being supported. This statement must be signed and dated.
3. Make sure to list every member of household. **Complete legal names, birth dates and Social Security numbers** are required.
4. If you have Medical Insurance coverage, please be sure to copy both sides of **Insurance cards to submit with this application.** This insurance information **will not** affect your discount for the Sliding Fee Program. Please include your **Medicare and/or Medicaid Card.**

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5. The Yearly Income section must be accurate:

a. Proof of income must be supplied for each household member. Acceptable proof of income is as follows:

1. Copy of the front of your most recent Federal 1040 tax return **OR**

2. Copy of most recent pay stub (must be within the last 30 days) **AND/OR**

3. Copies of other monthly income, if applicable:

a) Monthly Unemployment benefits

b) Monthly Worker's Compensation

c) Monthly Social Security

d) Monthly pension

e) Monthly rental income

f) Monthly child support

g) Other monthly income **AND/OR**

4. . If you or a household member is a college student with no income, a copy of your most current transcript or tuition bill must be submitted.

6. Please remember to **sign and date** your application.

Please carefully review your application for completeness and return to 5 Pine St, Glens Falls, NY 12801. If you have any question or need help with completing this application, please call 745-0079.

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	**At or Below 100%**	**125%**	**150%**	**175%**	**200%**	**Above 200%**
Family Size	**Pay 25% of co-pay** **Self-Pay is $25**	**Pay 40% of co-pay** **Pay 40% of self-pay**	**Pay 55% of co-pay** **Pay 55% of self-pay**	**Pay 70% of co-pay** **Pay 70% of self-pay**	**Pay 85% of co-pay** **Pay 85% of self-pay**	**Pay 100% of co-pay** **Pay 100% of self-pay**
1	0-$11,770	$11,771 $14,713	$14,714 $17,655	$17,656 $20,598	$20,599 $23,540	$23,541+
2	0-$15,930	$15,931 $19,913	$19,914 $23,895	$23,896 $27,878	$27879 $31,860	$31,861+
3	0-$20,090	$20,091 $25,113	$25,114 $30,135	$30,136 $35,158	$35,159 $40,180	$40,181+
4	0-$24,250	$24,251 $30,313	$30,314 $36,375	$36,376 $42,438	$42,439 $48,500	$48,501+
5	0-$28,410	$28,411 $35,513	$35,514 $42,615	$42,616 $49,718	$49,719 $56,820	$56,821+
6	0-$32,570	$32,571 $40,713	$40,714 $48,855	$48,856 $56,998	$56,999 $65,140	$65,141+
7	0-$36,730	$36,731 $45,913	$45,914 $55,095	$55,096 $64,278	$64,279 $73,460	$73,461+
8	0-$40,890	$40,891 $51,113	$51,114 $61,335	$61,336 $71,558	$71,559 $81,780	$81,781+
For each additional person, add	$4,160	$5,200	$6,240	$7,280	$8,320	$8,320

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OSIKA and SCARANO PSYCHOLOGICAL SERVICES, P.C.

SLIDING FEE PROGRAM APPLICATION

Last name | First Name | MI (use your full legal name)

Mailing Address | Town | State | Zip | Telephone number | E-mail address

PLEASE LIST YOURSELF, SPOUSE, & ALL HOUSHOLD MEMBERS AND DEPENDENTS

Name	Gender M/F	Relationship	Date of Birth Mo/Day/Year	Social Security Number	Have Medical Insurance Yes/No	Yearly Income

I certify that the above information is true and I hereby authorize Osika and Scarano Psychological Services to verify the above information. Osika and Scarano Psychological Services reserves the right to verification of any information supplied on this application. I will report any changes in my financial status to Osika and Scarano Psychological Services as those changes occur.

Head of Household Signature | Date