



See if you qualify for a discount in your healthcare fees!

Income Levels

- 1) Find your family size in the left column; follow that row to your amount of annual total family income.
- 2) Circle that column.
- 3) Your Counselor will let you know if you qualify for a discount.

Federal Schedule of Income (updated annually)

Family Size	Slide A		Slide B		Slide C		Slide D		Slide E		Slide F	
	From	To	From	To	From	To	From	To	From	To	From	To
1	\$0	\$11,770	\$11,771	\$14,713	\$14,714	\$17,655	\$17,656	\$20,598	\$20,599	\$23,540	\$23,541	& Over
2	\$0	\$15,930	\$15,931	\$19,913	\$19,914	\$23,895	\$23,896	\$27,878	\$27,879	\$31,860	\$31,861	& Over
3	\$0	\$20,090	\$20,091	\$25,113	\$25,114	\$30,132	\$30,136	\$35,158	\$35,159	\$40,180	\$40,181	& Over
4	\$0	\$24,250	\$24,251	\$30,313	\$30,314	\$36,375	\$36,376	\$42,438	\$42,439	\$48,500	\$48,501	& Over
5	\$0	\$28,410	\$28,411	\$35,513	\$35,514	\$42,615	\$42,616	\$49,718	\$49,719	\$56,820	\$56,821	& Over
6	\$0	\$32,570	\$32,571	\$40,713	\$40,714	\$48,855	\$48,856	\$56,998	\$56,999	\$65,140	\$65,141	& Over
7	\$0	\$36,730	\$36,731	\$45,913	\$45,914	\$55,095	\$55,095	\$64,278	\$64,279	\$73,460	\$73,460	& Over
8	\$0	\$40,890	\$40,891	\$51,113	\$51,114	\$61,335	\$61,336	\$71,558	\$71,559	\$81,780	\$81,781	& Over
Maximum Income as a % of Poverty	0-100%		101%-125%		126%-150%		151%-175%		176% 200%		>200%	
Discount from fee	100%		80%		60%		40%		20%		0%	
Nominal fee												
Indiv. Counseling	\$10											
Group Counseling	\$10											
Family Counseling	\$10											

For family units of more than 8 members, add \$4,160 for each additional member.

- I am providing my income details and I would also like to **apply** for Visionary Vanguard Group, Inc. Mental Health Counseling Sliding Fee Scale Program. (You will be required to complete a Sliding Scale Application and provide proof of the above stated income.)
- I am providing my income details however; I am **declining** the option to apply for Visionary Vanguard Group, Inc. Mental Health Counseling Sliding Fee Scale Program. (By Declining, I am accepting financial responsibility for the entire bill, including any fees that are **not** covered by my insurance plan and I agree to pay any balance in full)
- I am **declining** your request for income details. (By declining to provide income details, I am also declining the option to apply for Visionary Vanguard Group, Inc. Mental Health Counseling Sliding Fee Scale Program. Furthermore, I am accepting financial responsibility for the entire bill, including any fees that are **not** covered by my insurance plan and I agree to pay any balance in full)

Patient Name: _____

D.O.B.: _____

Patient Signature: _____

Date: _____

Staff Signature: _____

Date: _____