



Irby Psychological Services

Psychology · Counseling · Applied Behavior Analysis · Speech

Southaven

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Clarksdale

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Reduced Fee Request

For any client who is uninsured or underinsured, we will discount services (as outlined below) using this sliding fee scale. There is a commitment to eliminate financial barriers to receiving services. Therefore, the sliding scale fees are offered according to your household income and size:

Please select which service(s) you are receiving or would like to receive at IPS:

- | | |
|---|--|
| ☐ Speech therapy/Lactation/Tongue tie | ☐ Psychological testing |
| ☐ Counseling (individual/family therapy) | ☐ Intensive ABA (self-pay only for <i>up to</i> 5 hours/week) |
| ☐ Social group | ☐ Occupational therapy |
| ☐ Parent training | ☐ Physical therapy |

Step One: Fill in the following information.

Today's Date: / /			
Client's First Name:	Middle Name:	Last Name:	Date of Birth:
Home Address:		City:	State: Zip:
Primary Phone Number:		Alternative Phone Number:	

Step Two: provide the number of people in the household, gross monthly income for each person and total monthly income for the entire household.

First Name	Age	Monthly Income
1) You -		
2) Household member (specify)-		
3) Household member (specify)-		
4) Household member (specify)-		
5) Household member (specify)-		
6) Household member (specify)-		
7) Household member (specify)-		
8) Household member (specify)-		
Total Number of People in Household:	Total Monthly Income for Entire Household: \$	

Step Three: Locate the Number of People in Your Household on the Left Column of the Following Scale. Locate the column for the Total Monthly Income for Your Entire Household.

Step Four: Using the numbers from **Step Three**, locate Session Fee Corresponding to Number of People and Total Monthly Income for Entire Household, in the last shaded row on scale. Circle the fee that corresponds with your current income.

People in Household	A	B	C	D	E	F
1	\$0-\$1073	\$1074-\$1341	\$1342-\$1610	\$1611-\$1878	\$1879-\$2146	More than \$2146
2	\$0-\$1451	\$1452-\$1814	\$1815-\$2177	\$2178-\$2540	\$2541-\$2903	More than \$2903
3	\$0-\$1830	\$1831-\$2287	\$2288-\$2745	\$2746-\$3202	\$3203-\$3660	More than \$3660
4	\$0-\$2208	\$2209-\$2760	\$2761-\$3312	\$3313-\$3864	\$3865-\$4416	More than \$4416
5	\$0-\$2586	\$2587-\$3233	\$3234-\$3879	\$3880-\$4526	\$4527-\$5173	More than \$5173
6	\$0-\$2965	\$2966-\$3706	\$3707-\$4447	\$4448-\$5188	\$5189-\$5930	More than \$5930
7	\$0-\$3343	\$3344-\$4179	\$4180-\$5015	\$5016-\$5850	\$5851-\$6686	More than \$6686
8	\$0-\$3721	\$3722-\$4652	\$4653-\$5582	\$5583-\$6512	\$6513-\$7443	More than \$7443
Percentage of Financial Responsibility	10%	20%	40%	60%	80%	100%

Step Five: Check all that apply.

- ☐ I am currently unemployed (only if an individual living alone)
- ☐ I was referred to this clinic by _____
- ☐ If insured your individual/family deductible is: _____

Step Six: Identify your fee. This will either be by the fee that you circled in **Step Four** or if you checked “I am currently unemployed” in **Step Five** and you are an individual living alone, your fee is 10% of our full-price rate or if in **Step Five** your individual deductible is greater than \$5,000, then the fee percentage selected in **Steps Three** and **Four** will apply.

Step Seven: Sign and confirm information

I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from consideration for the sliding fee program. I agree to inform my therapist if there is a significant change in my income.

Signature: _____ Date: _____

PLEASE RETURN THIS FORM BEFORE YOUR FIRST SESSION

TO BE COMPLETED BY OFFICE STAFF:

My session fee is: \$ _____ per hour (includes individual/family therapy, as well as psychological testing); \$ _____ per hour (group rate); \$ _____ per hour (ABA rate)