

Tahoe Youth & Family Services

OUTPATIENT INTAKE AND PAYMENT PROCEDURES FOR INDIVIDUAL, FAMILY & GROUP COUNSELING

During the intake, we ask that you provide important basic information in order to assess your situation. If we are unable to assist you, we will offer other appropriate referrals in the community.

Individual/Family sessions last 50 minutes.

Group sessions last 1½ hours.

Payment Determination: Tahoe Youth & Family Services' actual cost of services is \$125.00 per individual/family session, \$35.00 per group counseling session. Use the attached sliding fee scale to determine your fee for service, based upon your gross monthly income and family size. A receipt will be provided for your insurance purposes. We will require verification of income in one of the following forms:

1. A recent paycheck stub;
2. AFDC, SSI, unemployment or disability verification;
3. Your most recent W-2 or tax return;
4. Copy of drug Medi-Cal and Social Security card.

Tahoe Youth & Family Services does require payment prior to the start of a session. Payments are made directly to the Office Manager. If you fail to pay for two (2) sessions, a third session will not be scheduled until your account is paid in full.

Please complete the form on page 2. A sliding fee scale for individual/family counseling sessions is on page 3. A sliding fee scale for group counseling is on page 4. Thank you.

INCOME VERIFICATION STATEMENT

The information below must be filled out completely and accurately. Fee schedules are based upon gross monthly income and household size. Tahoe Youth & Family Services will not refuse services to anyone demonstrating an *inability* to pay; however, Section 11841 of the present State of California Health & Safety Code requires that the agency collect a fee for any counseling provided whenever demonstrating an *ability* to pay.

Client's Name: _____ Date of Birth: ____ / ____ / ____

Responsible Party's Name: _____

Mailing Address: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Client's Social Security #: _____

Other Dependents: _____

Is your child currently receiving Medi-Cal benefits? Yes No

If "yes," please provide a copy of your card and the number: _____

Are you interested in Drug Medi-Cal which may make you eligible for free services? Yes No

GROSS MONTHLY INCOME

Source	Applicant	Spouse	Total
Employment	_____	_____	_____
Child Support	_____	_____	_____
Unemployment	_____	_____	_____
Social Security	_____	_____	_____
Disability	_____	_____	_____
Welfare/AFDC	_____	_____	_____
Other	_____	_____	_____

Article III, Section 1788 of the California State Civil Code makes it a violation of the law for any recipient of consumer credit to submit false or inaccurate information or willfully conceal adverse information bearing upon his credit worthiness, credit standing or credit capacity, or to fail to notify this office within a reasonable amount of time, of any change in name, address or employment.

The preceding financial information is true and accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: ____ / ____ / ____

SLIDING FEE SCALE FOR INDIVIDUAL & FAMILY SESSIONS

Verification of family income is required by submitting a copy of a recent check stub, tax form, or bank statement. AFDC, SSI, unemployment, and disability income recipients are eligible for a fee waiver with documentation of such income.

Monthly Gross Income	Number in Household					
	1	2	3	4	5	6 & over
0 – 1000	30	30	30	30	30	30
1001 – 1500	35	35	35	35	30	30
1501 – 2000	45	45	40	40	35	30
2001 – 2500	50	50	45	45	35	35
2501 – 3000	55	55	50	50	45	40
3001 – 3500	60	60	55	55	50	45
3501 – 4000	65	65	60	60	55	50
4001 – 4500	70	70	65	65	60	55
4501 – 5000	75	75	75	70	65	60
5001 – 5500	80	80	80	75	70	65
5501 – 6000	85	85	85	80	75	70
6001 – 6500	90	90	90	85	80	75
6501 – 7000	95	95	95	90	85	80
7001 – 8000	100	100	100	100	100	100
8001 – 9000	125	125	125	125	125	125

I, _____, do hereby agree to the terms set forth in the following contract agreement for outpatient individual and family sessions. **According to the sliding scale above, my fee is \$ _____ per session.** Please speak to the front office if you need a payment plan.

I am unable to pay the above fee; I am able and agree to pay a fee of _____ per session, due at the time of the session. _____ Initials

- If you or your child receives services at Tahoe Youth & Family Services, your fee is due at the beginning of each session. If your child receives services at a school site, the agency will bill you for your services. Please do not send your child to school with the payment.
- Tahoe Youth & Family Services reserves the right to discontinue services due to lack of payment. Failure to comply with the provisions of the financial contract may result in the termination of services until past due fees have been paid in full.
- Cancellations must be made within 24 hours before your scheduled session, or you will be charged your usual fee. Fee may be waived for good cause.
- If you fail to show for two sessions without notice, you may be terminated from services.

_____/_____/_____
Parent/Guardian Signature *Date*

_____/_____/_____
Office Manager Signature *Date*

SLIDING FEE SCALE FOR GROUP COUNSELING

Verification of family income is required by submitting a copy of a recent check stub, tax form, or bank statement. AFDC, SSI, unemployment, and disability income recipients are eligible for a fee waiver with documentation of such income.

Monthly Gross Income	Number in Household					
	1	2	3	4	5	6 & over
0 – 1000	5	5	4	3	2	0
1001 – 1500	7	5	5	3	2	0
1501 – 2000	9	7	6	5	4	2
2001 – 2500	11	9	8	7	6	4
2501 – 3000	13	11	10	9	8	6
3001 – 3500	15	13	12	11	10	8
3501 – 4000	17	15	14	13	12	10
4001 – 4500	19	17	16	15	14	12
4501 – 5000	21	19	18	17	16	14
5001 – 5500	23	21	20	19	18	16
5501 – 6000	25	23	22	21	20	18
6001 – 6500	27	25	24	23	22	20
6501 – 7000	29	27	26	25	24	22
7001 & above	35	35	35	35	35	35

I, _____, do hereby agree to the terms set forth in the following contract agreement for group sessions. **According to the sliding scale above, my fee is \$ _____ per session.** Please speak to the front office if you need a payment plan.

I am unable to pay the above fee; I am able and agree to pay a fee of _____ per session, due at the time of the session. _____ Initials

- If you or your child receives services at Tahoe Youth & Family Services, your fee is due at the beginning of each group session. If your child attends a group at a school site, the agency will bill you for your services. Please do not send your child to school with the payment.
- Tahoe Youth & Family Services reserves the right to discontinue services due to lack of payment. Failure to comply with the provisions of the financial contract may result in the termination of services until past due fees have been paid in full.
- Cancellations must be made within 24 hours before the scheduled group session, or you will be charged your usual fee. Fee may be waived for good cause.
- If you fail to show for two group sessions without notice, you may be terminated from services.

Parent/Guardian Signature _____/_____/_____
Date

Office Manager Signature _____/_____/_____
Date