SLIDING SCALE FEE

APPLICATION AND FEE AGREEMENT 12/2025

THE CHILD CENTER OF NY
Strengthening Family. Building Community.

Client Name: _____ Phone: _____ Date of Birth: _____

Home Address: _____ Billing Address: _____

Name of Person Responsible for Payment: _____ Relationship to Client: _____

Have you applied for Medicaid? YES ☐ NO ☐ If yes, what was the result? _____

INCOME SOURCES				
Sources	Amount ($)	Weekly	Bi-Weekly	Annually
Salaries (Self)		☐	☐	☐
Salaries (Spouse or Other)		☐	☐	☐
Worker's Compensation		☐	☐	☐
Social Security (Children)		☐	☐	☐
SSI		☐	☐	☐
Child Support / Alimony		☐	☐	☐
Military Benefits		☐	☐	☐
Unemployment		☐	☐	☐
Other		☐	☐	☐
Total Income		☐	☐	☐

HOUSEHOLD MEMBER		
Name	Age	Relationship
Total # of Household Members		

PROOF OF INCOME PROVIDED

Please check the box next to each document provided:

☐ Federal Income Tax Forms
☐ Last two (2) pay stubs
☐ Current bank statements
☐ Printout from Social Security
☐ Court order for support
☐ Employer letter for cash wages
☐ Child's CHP ID
☐ Letter from supporting caregiver
☐ Personal attestation

Using the chart on the next page, the Sliding Scale Fee is: _____ per individual visit, _____ per group visit

The Child Center of NY accepts many insurances, including Medicaid, and offers uninsured individuals discounted rates that are applied to all equally and fairly and are based on documented income below 200% of the Federal Poverty Level, family size, and federal guidelines. I declare that the information I provided in this application is true and correct, and that I have read and understand the *Sliding Scale Fee Chart*. I agree to notify The Child Center of NY of any changes in this information within one month of such change and that I must requalify every year to maintain eligibility. I am aware that the Sliding Scale Fees are based on Federal Poverty Guidelines and that The Child Center of NY must adhere to them for all applicants. I agree to apply for Medicaid, if eligible, or risk losing my Sliding Scale Fee. I understand and agree that all fees are due and payable at the time of service, and that failure to either provide income verification documents or failure to pay the Sliding Scale Fee will result in discharge from the program. I have read and agree to abide by *The Child Center of NY Client Payment Policy*. Unless I, or my child, qualify for healthcare benefits and remain covered for each visit, I agree to pay The Child Center of NY for services rendered to me or my child at the above rates.

Applicant or Responsible Party Signature	*Print Name*	*Date*
Program Representative Signature	*Print Name*	*Date*

SLIDING SCALE FEE

Chart 12/2025

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Household Size (Including unborn child)	Income Timeframe Measured	1 *0% - 100% of Federal Poverty Level*	2 *101% - 133% of Federal Poverty Level*	3 *134% - 166% of Federal Poverty Level*	4 *167% - 200% of Federal Poverty Level*	5 *Above 200% of Federal Poverty Level*
1	Annual Bi-Weekly	$0 - $15,650 $0 - $602	$15,651 - $20,815 $603 - $801	$20,816 - $25,979 $802 - $999	$25,980 - $31,300 $1,000 - $1,204	$31,301 + $1,205 +
2	Annual Bi-Weekly	$0 - $21,150 $0 - $813	$21,151 - $28,130 $814 - $1,082	$28,131 - $35,109 $1,083 - $1,350	$35,110 - $42,300 $1,351 - $1,627	$42,301 + $1,628 +
3	Annual Bi-Weekly	$0 - $26,650 $0 - $1,025	$26,651 - $35,445 $1,026 - $1,363	$35,446 - $44,239 $1,364 - $1,702	$44,240 - $53,300 $1,703 - $2,050	$53,301 + $2,051 +
4	Annual Bi-Weekly	$0 - $32,150 $0 - $1,237	$32,151 - $42,760 $1,238 - $1,645	$42,761 - $53,369 $1,646 - $2,053	$53,370 - $64,300 $2,054 - $2,473	$64,301 + $2,474 +
5	Annual Bi-Weekly	$0 - $37,650 $0 - $1,448	$37,651 - $50,075 $1,449 - $1,926	$50,076 - $62,499 $1,927 - $2,404	$62,500 - $75,300 $2,405 - $2,896	$75,301 + $2,897 +
6	Annual Bi-Weekly	$0 - $43,150 $0 - $1,660	$43,151 - $57,390 $1,661 - $2,207	$57,391 - $71,629 $2,208 - $2,755	$71,630 - $86,300 $2,756 - $3,319	$86,301 + $3,320 +
7	Annual Bi-Weekly	$0 - $48,650 $0 - $1,871	$48,651 - $64,705 $1,872 - $2,489	$64,706 - $80,759 $2,490 - $3,106	$80,760 - $97,300 $3,107 - $3,742	$97,301 + $3,743 +
8	Annual Bi-Weekly	$0 - $54,150 $0 - $2,083	$54,151 - $72,020 $2,084 - $2,770	$72,021 - $89,889 $2,771 - $3,457	$89,890 - $108,300 $3,458 - $4,165	$108,301 + $4,166 +
Sliding Scale Fee		**$0**	**$30**	**$45**	**$60**	Therapy Session — $150
Group Fee		**$0**	**$12**	**$18**	**$24**	**$60**
Supportive Services *For CCBHC Only*		**$0**	**$12**	**$18**	**$24**	**$60**
Assessments-Only		**$205** — Not Eligible for Sliding Scale Fee (DMV, Court referred, DA referred, Lawyer referred and must be collected before service rendered)				

All fees are due at the time of service and acceptable forms of payment are cash, credit/debit card, or money order.
No personal checks are accepted.

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