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Sliding Scale Chart

GROSS INCOME RANGE - FEE per HOUR* BASED ON NUMBER OF PERSONS LIVING IN THE HOME
 *Not to exceed four (4) co-pays per calendar month

<u>ANNUAL</u>	<u>MONTHLY</u>	<u>GROUP RATE</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>
\$0 - 7,500	\$ 418 - 625	\$0	\$1	0	0	0	0	0
7,501 - 10,000	626 - 833	\$0	\$2	1	0	0	0	0
10,001 - 12,500	834 - 1,042	\$0	\$3	2	1	0	0	0
12,501 - 15,000	1,043 - 1,250	\$0	\$4	3	2	1	0	0
15,001 - 17,500	1,251 - 1,458	\$0	\$5	4	3	2	1	0
17,501 - 20,000	1,459 - 1,667	\$1	\$6	5	4	3	2	1
20,001 - 22,500	1,668 - 1,875	\$2	\$7	6	5	4	3	2
22,501 - 25,000	1,876 - 2,083	\$3	\$8	7	6	5	4	3
25,001 - 27,500	2,084 - 2,292	\$4	\$9	8	7	6	5	4
27,501 - 30,000	2,293 - 2,500	\$5	\$10	9	8	7	6	5
30,001 - 32,500	2,501 - 2,708	\$6	\$11	10	9	8	7	6
32,501 - 35,000	2,709 - 2,916	\$7	\$12	11	10	9	8	7
35,001 - 37,500	2,917 - 3,125	\$8	\$13	12	11	10	9	8
37,501 - 40,000	3,126 - 3,333	\$9	\$14	13	12	11	10	9
40,000 - 42,500	3,334 - 3,542	\$10	\$15	14	13	12	11	10

After reviewing the Sliding Scale Chart of **HFCS**, I agree to pay \$_____ for each hour of service **OR** a maximum calendar month out of pocket of \$_____. (Sum of 4 co pays)

To my knowledge, I do not have insurance benefits that cover the services being provided. I agree to inform **HFCS** if I obtain benefits that cover the services being provided.

 Client Name

 Date

 Guarantor Printed Name

 Signature

 Relationship to Client

HFCS Representative