

Financial Assistance Qualification

Northern Pines Mental Health Center offers financial assistance for those that qualify. The determining factors for financial assistance are:

* *Gross Family Income* – The amount of income from wages and salaries, but not limited to, coming into one household
* *Household Size* – The number of people residing, as primary residency, within a household

Financial Assistance applications are available by request to all clients after an Insurance Navigation appointment is completed. Only those already qualifying for any type of Medicaid funding may apply for financial assistance without an insurance navigation appointment.

**To apply for financial assistance, please reach out the Finance Office at 320-632-6647, option 2, to request an Insurance Navigation Appointment.** Alternatively, you can request an appointment online at [www.npmh.org](http://www.npmh.org) by clicking on “Client Financial Info.,” followed by “Financial Support Services.” Completed applications can be mailed to PO Box 367, Little Falls, MN 56345, or submitted online at NPMH.org. Based on family income and household size, NPMH will use the Northern Pines Mental Health Center Sliding Fee Schedule on Page 2 of this packet. Approval of Financial Assistance is based on 365 days from the approval date. Please reapply for Financial Assistance upon expiration in order to be considered for continued reduced fees.

If you need any assistance completing this form, please ask a Support Specialist at any NPMH location, or feel free to call 320-632-6647, option 2.

**NORTHERN PINES MENTAL HEALTH CENTER, INC. SLIDING FEE SCHEDULE**

Match household size to the number equal to or less than the household gross income on the chart below. The Fee at the bottom of that column is the sliding fee.

|  |  |
| --- | --- |
| **Family** **Size**  |  **Gross Income is equal to or less than: (circle one)** |
|  | 100% | 110% | 120% | 130% | 140% | 150% | 160% | 170% | 180% | 190% | 200% | 210% | 220% | 230% | 240% | 250% | 260% | 270% | 275% |
| one | $13,590  | $14,949  | $16,308  | $17,667  | $19,026  | $20,385  | $21,744  | $23,103  | $24,462  | $25,821  | $27,180  | $28,539  | $29,898  | $31,257  | $32,616  | $33,975  | $35,334  | $36,693  | $37,373  |
| two | $18,310  | $20,141  | $21,972  | $23,803  | $25,634  | $27,465  | $29,296  | $31,127  | $32,958  | $34,789  | $36,620  | $38,451  | $40,282  | $42,113  | $43,944  | $45,775  | $47,606  | $49,437  | $50,353  |
| three | $23,030  | $25,333  | $27,636  | $29,939  | $32,242  | $34,545  | $36,848  | $39,151  | $41,454  | $43,757  | $46,060  | $48,363  | $50,666  | $52,969  | $55,272  | $57,575  | $59,878  | $62,181  | $63,333  |
| four | $27,750  | $30,525  | $33,300  | $36,075  | $38,850  | $41,625  | $44,400  | $47,175  | $49,950  | $52,725  | $55,500  | $58,275  | $61,050  | $63,825  | $66,600  | $69,375  | $72,150  | $74,925  | $76,313  |
| five | $32,470  | $35,717  | $38,964  | $42,211  | $45,458  | $48,705  | $51,952  | $55,199  | $58,446  | $61,693  | $64,940  | $68,187  | $71,434  | $74,681  | $77,928  | $81,175  | $84,422  | $87,669  | $89,293  |
| six | $37,190  | $40,909  | $44,628  | $48,347  | $52,066  | $55,785  | $59,504  | $63,223  | $66,942  | $70,661  | $74,380  | $78,099  | $81,818  | $85,537  | $89,256  | $92,975  | $96,694  | $100,413  | $102,273  |
| seven | $41,910  | $46,101  | $50,292  | $54,483  | $58,674  | $62,865  | $67,056  | $71,247  | $75,438  | $79,629  | $83,820  | $88,011  | $92,202  | $96,393  | $100,584  | $104,775  | $108,966  | $113,157  | $115,253  |
| eight  | $46,630  | $51,293  | $55,956  | $60,619  | $65,282  | $69,945  | $74,608  | $79,271  | $83,934  | $88,597  | $93,260  | $97,923  | $102,586  | $107,249  | $111,912  | $116,575  | $121,238  | $125,901  | $128,233  |
| For family units with more than 8 members, add $4,790 to annual income for each additional member. For > 1 client / family, add 1 size to family for each client. |
| **CLIENT RESPONSIBILITY-** Diagnostic/Comprehensive Assessment, Individual Therapy, and Individual SUDS. |
| EACHVISIT | $0 | $0 | $10 | $10 | $20 | $20 | $30 | $30 | $40 | $40 | $50 | $50 | $75 | $75 | $100 | $100 | $125 | $125 | Full Fee |
| **CLIENT RESPONSIBILITY**-All other qualifying services. |
| EACH VISIT | $0 | $0 | $0 | $0 | $15 | $15 | $15 | $15 | $25 | $25 | $25 | $25 | $35 | $35 | $35 | $35 | $45 | $45 | Full Fee |

\*Incomes above the amounts in the 275% column do not qualify for sliding fees.

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|  | Northern Pines Mental Health Center**For Office Use Only:**Insurance Navigation Findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Navigator Initials & Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\*\*Insurance Navigation is required prior to reduced fee consideration in most circumstances.* |

## Sliding Fee Application

\*Northern Pines Mental Health Center will provide services to all individuals regardless of their ability to pay.

|  |
| --- |
| Applicant Information |
|

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  |  |
|  | Last | First | M.I. |
| Address: |  |  |  |
|  | Street Address |  | Apartment/Unit # |
|  |  |  |  |
|  | City | State | ZIP Code |
| Date of Birth: |  |  Home Phone:  |  |

Health Insurance Plan Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy ID(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Northern Pines Location for Services:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason(s) for applying: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| . Income and Expenses Information . |

|  |  |
| --- | --- |
| **Monthly Income:** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Other income (If any):** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Please attach proof* **Household Size:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*The number of people residing, as primary residency, within a household* | **Additional Information (optional):**  |

\*\*Please include the following **(required):** \*\*

*Copy of One Month of Pay Stubs* and/or *1040 Tax Form*

*I understand that if this application is approved for reduced or waived fees, that the approval will be effective for one year and I will be responsible to reapply for assistance for future consideration.*

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you need any assistance completing this form, please ask a Support Specialist at any NPMH location, or feel free to call 320-632-6647, option 2.

ይህን ቅጽ በመሙላት ላይ እገዛ ከፈለጉ፣ እባክዎን ወደ ማናቸውም የ NPMH የሚገኝባቸው ቦታዎች በመሄድ የድጋፍ ሰጪ ልዩ ባለሞያ እንዲቀርብልዎ ይጠይቁ ወይም እንደ ኣማራጭ 2 ወደ 320-632-6647 ይደውሉ።

إذا كنت بحاجة إلى أي مساعدة بشأن ملء هذا النموذج، يُرجى استشارة أحد متخصصي الدعم المتواجدين في أي موقع من مواقع مركز نورثرن باينز للصحة العقلية (NPMH)، أو اتصل على ‎320-632-6647، كخيار ثانٍ.

ဤဖောင်ဖြည့်စွက်ရန် အကူအညီလိုအပ်ပါက NPMH နေရာတစ်ခုရှိ ပံ့ပိုးရေးကျွမ်းကျင်သူ(Support Specialist) တစ်ဦးကို မေးမြန်းပါ သို့မဟုတ် 320-632-6647 ရွေးချယ်စရာ 2 ကို ဖုန်းခေါ်ဆိုပါ။

បើអ្នកត្រូវការជំនួយណាមួយក្នុងការបំពេញទម្រង់បែបបទនេះ សូមស្នើសុំអ្នក​ឯក​ទេសផ្នែកគាំទ្រនៅទីតាំង NPMH ណាមួយ ឬហៅទូរសព្ទមកលេខ 320-632-6647 ដោយសេរី
ជម្រើសទី 2 ។

如果您在填写此表格时需要任何协助，请咨询任何 NPMH 地点的支持专家，或随时拨打电话 320-632-6647，选项 2。

Si vous avez besoin d’aide pour remplir ce formulaire, veuillez vous renseigner auprès d’un agent spécialisé dans n’importe quel centre NPMH, ou bien appeler le 320-632-6647, option 2.

Yog tias koj xav tau kev pab teb kom tiav daim foos no, thov nug Tus Kws Tshaj Lij Pab Txhawb ntawm NPMH txhua qhov chaw, los sis hu rau 320-632-6647, qhov kexaiv 2.

န့မၢ်လိၣ်ဘၣ် တၢ်မၤစၢၤတခါခါလၢ တၢ်ကမၤပှဲၤ လံ၁်ဒိအံၤန့ၣ်, ၀ံသးစူၤ သံကွၢ်ဘၣ် တၢ်ဆီၣ်ထွဲမၤစၢၤပှၤသ့ပှၤဘၣ် ဖဲ NPMH တၢ်လီၢ်တၢ်ကျဲ တတီၢ်တီၢ်, မ့တမ့ၢ် ကိးဘၣ် 320-632-6647, တၢ်ဃုထၢ 2.

이 양식을 작성하시는 데 도움이 필요하시면, NPMH 사업장에 있는 어느 고객지원 담당자에게든 문의하시고, 또는 320-632-6647 (내선 2)로 연락하십시오.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການປະກອບແບບຟອມນີ້, ກະລຸນາສອບຖາມຜູ້ຊ່ຽວຊານຝ່າຍການຊ່ວຍເຫຼືອຢູ່ສະຖານທີ່ NPMH ໃດໆກໍໄດ້ ຫຼື ຈະໂທຫາ 320-632-6647, ຕົວເລືອກ 2 ກໍໄດ້.

Uunka kana guutuuf deeggersa kamiyyuu yoo barbaaddan, maaloo Ispeeshaalistii Gargaarsaa NPMH iddoo kamittuu argamu gaafadhaa, ykn sodaa tokko malee 320-632-6647 irratti bilbilaa, filannoo 2.

Если вам нужна помощь в заполнении этой формы, пожалуйста, обратитесь к специалисту службы поддержки в любом офисе NPMH или позвоните по номеру 320-632-6647, вариант 2.

Haddii aad u baahan tahay wax caawimaad ah oo la xariirta buuxinta foomkaan, fadlan Khabiir Ku Caawiya ka codso xarun uun ay NPMH leedahay, ama haka meermeerin inaad wacdo 320-632-6647, dookha 2 aad.

Si necesita ayuda para completar este formulario, solicítesela al especialista en servicios de apoyo en cualquiera de nuestros centros de NPMH o llame al 320-632-6647, opción 2.

Nếu quý vị cần hỗ trợ điền biểu mẫu này, hãy yêu cầu Chuyên gia Hỗ trợ tại các địa điểm NPMH hoặc gọi 320-632-6647, chọn 2.