The Saluda Counseling Center

Care Fund Policy

The purpose of the Care Fund is to provide assistance to those clients who do not have insurance or otherwise would not be able to afford therapy and medication management. Approval is at the discretion of the Care Fund Committee and based on income guidelines and available funds at the time of application.

The Care Fund Committee is comprised of three staff members to include an employee from the clinical department, the administrative department, and a member of leadership. In addition, the internal committee will report to one or more of the Board of Directors whom will be appointed as liaison(s) for the Board.

Please refer to the following guidelines:

- Client cannot have commercial mental health insurance coverage, or Medicare.
- Client will pay a fee to the fullest extent possible with a minimum payment of $5.00 per session.
- Each application can be for a maximum of 12 visits and the committee will determine dollar amount based on current charges and patient income.
- Client must start using their Care Fund vouchers within the same month of the approval date or they will be void.
- If more than 1 scheduled visit is missed, any remaining vouchers will be void
- Unused vouchers expire three months after the approval date, and a new application can be submitted after vouchers expire or after the last voucher is used.
- Care Fund monies can be used for past visits unless client had insurance coverage during that time period. However, clients are still held responsible for any past due balance billed to insurance.
- Care Fund monies can only be used to pay for therapy visits OR in order for monies to be used towards medical services the patient must be actively seeing a therapist. Proper releases must be completed for the outside therapy service provider
- The Care Fund Committee will meet on the third Thursday of every month. Proof of income for your application must be received prior to the monthly meeting in order to have your application reviewed.
- Applications can be obtained from the administrative staff or on our website and returned to The Saluda Counseling Center once completed for review. They will then meet with the designated Care Fund Committee member to review the policy and sign their application.
- Client must attend and pay a minimum payment upon scheduling of $25 for initial therapy sessions, and a minimum payment upon scheduling of $65 for initial medical assessment before being considered for Care Fund.
- All special circumstances are considered on a case by case basis by the Committee.

Applicant Signature: _____ Date: _____

The Saluda Counseling Center

Care Fund Application

Date:_____

Client Name:_____Date of Birth:_____ MR#:_____

1) Number of people in household: _____

2) Household Income (Monthly):_____

3) Explanation of Financial Status (i.e.: unusual circumstances or specific stressors):_____

_____

_____

4) Have you been seen at The Saluda Counseling Center before? Yes ☐ No ☐ If yes, when? _____

5) Do you have commercial insurance or Medicare? Yes ☐ No ☐

6) If yes, is mental health covered under your benefits? Yes ☐ No ☐

I have read and understand the Care Fund policy and by signing below I acknowledge that I understand this policy, and that I have reported my total income. I understand that I am required to report any change in income upon this change.

_____ _____

Client's Signature Date

The Saluda Counseling Center

Care Fund Application

Client Name:_____Date of Birth:_____ MR#:_____

For Provider's Use Only:

Provider's Name: _____

Requested number of visits in the next 3 months: _____

Clinical Information (attach a separate sheet if needed):_____

_____

_____

For Administrative Use Only:

Is there a past due balance? Yes ☐ No ☐

If yes, how much is past due? _____

If applicable, has a payment plan been established for this past due balance? Yes ☐ No ☐

Is this the first application for this client? Yes ☐ No ☐ If no, how many times has the client applied? _____

Has the client provided proof of income for this application? Yes ☐ No ☐

Total Amount of Request from Care Fund: $_____ X _____ visits = $_____

Notes:_____

_____

Date Reviewed:

Approved ☐ Denied ☐

Committee Signatures: 1)_____

2)_____

3)_____

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