JOHN R DAY & ASSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

SLIDING FEE DISCOUNT APPLICATION

It is the policy of Christian Psychological Associates to provide counseling services to those with no insurance or insurance with whom we are not in network. Discounts are offered based on family size and annual income. ***The discount will apply to counseling services only***. This form must be completed every 12 months or if your financial situation changes.

Please complete the following information and return to the office to determine if you or members of your family are eligible for a discount. If completing online, please email the completed form to home@christianpsychological.org or **fax to 309-692-2262**. The sooner we receive the application, the sooner you will know your discounted fee if any.

Name of Responsible Party*: _____ **Phone Number:** _____

* The Responsible Party is the person who initiates counseling/therapy for self or minor dependent. Please see the Financial Policy for more details.

Please list spouse/partner and dependents under age 18.

Name	Relationship	Age

Annual Household Income

Source	Self	Spouse	Dependent under 18	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

IMPORTANT: Please send a copy of your most recent Tax Return and 2 most recent pay stubs with your application before a discount can be approved. Application may be rejected due to lack of sufficient proof of income.

I certify that the family size and income information shown above is correct. I understand that any misleading information or omissions may disqualify me from the discount program, and I will be responsible for the full fee of all visits.

Signature: _____ **Date:** _____

Office Use Only

Approved Discount: _____ Approved By: _____ Date Approved: _____

Verification Checklist	Yes	No
Prior year's tax return		
Two most recent pay stubs		
Insurance card (s) including Medicaid card		

Reason Not Approved: _____ By: _____ Date: _____