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**Sliding Fee Discount Application**

It is the policy of TouchStone Behavioral Health to provide essential services regardless of the patient’s ability to pay. Discounts are offered based on family size and annual income. **Please complete the following information and return to the front desk** to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, and must be completed every 12 months or when your financial situation changes.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Head of Household | | | Place of Employment | |
| Street | City | State | Zip | Phone |

**Please list spouse and dependents under age 18.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Name | Date of Birth |  | Name | Date of Birth |
| Self |  |  | Dependent |  |  |
| Spouse |  |  | Dependent |  |  |
| Dependent |  |  | Dependent |  |  |
| Dependent |  |  | Dependent |  |  |

**Annual Household Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Self** | **Spouse** | **Other** | **Total** |
| Gross wages, salaries, tips, etc |  |  |  |  |
| Income from business, self-employment, and dependents |  |  |  |  |
| Unemployment compensation, social security, supplemental security income, public assistance, veterans’ payments, survivor benefits, pension or retirement income |  |  |  |  |
| Interest, dividends, rents, royalties income from estates, trusts, educational assistance from outside the household, and other miscellaneous sources |  |  |  |  |
| **Total Income** |  |  |  |  |

**Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.**

I certify that the family size and income information shown above is correct.

Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Use Only**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved Discount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Verification Checklist** | **Yes** | **No** |
| Identification/address: Driver’s license, utility bill, employment ID, or other |  |  |
| Income: Prior year tax return, three most recent pay stubs, or other |  |  |
| Insurance: Insurance cards |  |  |