STRIVE
Towards better mental health

Sliding Fee Discount Application

It is the policy of Strive Mental Health LLC to provide essential services regardless of the patient's ability to pay. Strive Mental Health LLC offers discounts based on family size and annual income.

Please complete the following information and return it 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, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

NAME	**PHONE #**

STREET	**CITY**	**STATE**	**ZIP**

Please list all household members, including those under age 18.

	NAME	**DATE OF BIRTH**
SELF		
OTHER		
OTHER		
OTHER		
OTHER		

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SOURCE	SELF	OTHER	TOTAL
Gross wages, salaries, tips, etc.			
Income from business and selfemployment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
TOTAL INCOME			

Please include supporting documents for verification purposes.

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

Name (Print) _____

Signature _____ Date _____

OFFICE USE ONLY

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

VERIFICATION CHECKLIST	YES	NO
Identification/Address: **Driver's license, utility bill, employment identification, or other**		
Income: **Prior year tax return, three most recent pay stubs, or other**		

Self-declaration of income may also be used.