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 or email it to strive@strivementalhealthllc.com 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 performed somewhere else (i.e. GeneSight, labwork, etc.). You must complete this form every 12 months or if your financial situation changes.

Applicant Information

Full Name: _____ Date of Birth: _____

Phone #: _____ Email: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Household Information

Total Number of Household Members (including those under age 18): _____

Total Household Income: $_____ Monthly / Annually *(circle one)*

*****You must attach proof of income, such as pay stubs, tax returns, or other supporting documents for your application to be reviewed.***

Certification and Signature

I certify that the information provided above is accurate & complete to the best of my knowledge.

Signature: _____ Date: _____

For Office Use Only

Application Received By: _____ Date Received: _____

Income Verified: (Y / N) Discount Approved: (Y / N) Approved Discount: _____%

Authorized By: _____ Date Approved: _____