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# Sliding Fee Scale Application

## Applicant Information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  |  | | |  | |
|  | Last | First | | | M.I. | |
| Address: |  | | | | |  |
|  | Street Address | | | | | Apartment/Unit # |
|  |  | | | |  |  |
|  | City | | | | State | ZIP Code |
| Phone: |  | | Email: |  | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date Available: | |  | | Social Security No: | |  | Date of Birth: |  | |
| Marital Status: | Single | | Married | Divorced/Separated | Widowed | | | |

## Responsible Party

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Guarantor Name: |  | |  | |  | |
|  | Last | | First | | Middle | |
| Relationship to Applicant: | |  | |
| Employer: | |  | | Phone: | |  |
| Social Security Number: | |  | | | | |

## Household Members

Name/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unemployed/Minor

Name/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unemployed/Minor

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Name/Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unemployed/Minor

## Annual Household Income

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Self** | **Spouse** | **Other** | **Total** |
| Gross wages, salaries, tips, etc. |  |  |  |  |
| Income from business, self-employment, and dependents |  |  |  |  |
| Unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veterans’ payments, survivor benefits, pension of 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** |  |  |  |  |

## Medicaid Information

|  |  |  |
| --- | --- | --- |
| Do you have Medicaid benefit coverage? | YES | NO |

If yes, please complete:

|  |  |  |  |
| --- | --- | --- | --- |
| Medicaid Insurance Name: |  | | |
| Medicaid Number: |  | | | Effective Date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If no, are you eligible for Medicaid benefit coverage? | | YES | NO |

## Income Verification

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***Please attach copies of income verification**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Please remember that you will remain as a self-pay client until this information is received. Unless income verification is provided, you will be held liable for the full amount of charges. The sliding fee scale discount only applies to charges incurred with services by our clinicians in and/or outside the agency.

**Applicants must provide one of the following for income verification: prior year W-2, two most recent pay stubs, letter from employer, or form 4506-T (if W-2 not filed), signed statement of income from other source (family member). If self-employed- a detailed breakdown of income and expenses for past 3 months.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I verify that this information presented is true and accurate to the best of my knowledge and hereby apply for the sliding fee scale discounts as applicable.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

## Office Use Only:

|  |  |  |  |
| --- | --- | --- | --- |
| Chart/Client Number: |  | Sliding Fee Percentage: |  |
| Approved By: |  | Date: |  |
| Effective Date of SFS Discount: |  |