

*Turning Leaf Counseling, Inc*

103 East State Street Suite 301 Mason City, IA 50401

641-421-2089 • [info@turningleafcounseling.com](mailto:info@turningleafcounseling.com) • [www.turningleafcounseling.com](http://www.turningleafcounseling.com)

## Sliding Fee Application Form

Date of Completion: _____ Referral Source: _____	
Patient Name: _____ DOB: _____ Race: _____ Sex: _____	
Address: _____	
City: _____ State: _____ Zip Code: _____	
<b>*Please complete the section below if there is more than one person contributing to income</b>	
Guardian/Parent Name: _____ DOB: _____ Race: _____ Sex: _____	
Driver's License No.: _____ SS#: _____	
Phone Numbers: Home _____ Office _____ Cell _____	
Place(s) of employment: _____ Occupation/Trade: _____	
<b>*Please complete the section below if there is more than one person contributing to income</b>	
Guardian/Parent Name: _____ DOB: _____ Race: _____ Sex: _____	
Driver's License No.: _____ SS#: _____	
Phone Numbers: Home _____ Office _____ Cell _____	
Place(s) of employment: _____ Occupation/Trade: _____	

**OFFICE USE ONLY**

You understand you have a financial responsibility for services. This contract will be valid for a minimum of 6-months, but up to a one year period of eligibility starting on \_\_\_\_\_. You will need to be re-qualified for services on my anniversary date, which is \_\_\_\_\_.

You understand you must bring in current documentation at the point of my annual anniversary.

Patient / Guardian Signature \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

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**Number of persons living in your household:** \_\_\_\_\_

*Income Verification: Submit a copy only the last 2 pay stubs, or last year's tax statement, or employer's statement of income on letterhead, or self-employment records, or child support verification, for each source of income.*

**Person(s) contributing to income: Household Member(s) Household Income (Complete relevant column(s))**

Name of Person with Income	Source of Income	How often Received? (weekly, bi-weekly, monthly)	Total Amount Received Annual
Combined Annual Income: _____			

***\*Supporting proof of documented income required***

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved and will be provided as may be requested.

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

\_\_\_\_\_  
Signature: Date:

<b>Office Use Only</b>	
Client Name: _____	
Fee for Initial Assessment Service: _____	Fee for Individual Therapy: _____
Fee for Family Therapy: _____	Other Service: _____ Fee: _____
Date Range of Service Start: _____/End: _____ Approved By: _____	