Turning Leaf Counseling, Inc
103 East State Street Suite 301 Mason City, IA 50401
641-421-2089 ▪ info@turningleafcounseling.com ▪ www.turningleafcounseling.com

Sliding Fee Application Form

Date of Completion:_______________ Referral Source:_____________________

Patient Name:__________________ DOB:_______________ Race:___________ Sex:_______

Address:____

City:______________________________ Sate:__________ Zip Code:___________________

*Please complete the section below if there is more than one person contributing to income

Guardian/Parent Name:_______________________ DOB:______________ Race:________ Sex:_____

Driver's License No.:____________________________

Phone Numbers: Home____________________ Office__________________ Cell________________

Place(s) of employment:______________________________ Occupation/Trade:__________________

***Please complete the section below if there is more than one person contributing to income**

Guardian/Parent Name:_______________________ DOB:______________ Race:________ Sex:_____

Driver's License No.:____________________________

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:

Office Use Only

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:____________________