Patient Application for the Sliding Fee Discount Program

It is the policy of Connections Therapy Center to provide essential services regardless of the patient’s ability to pay. We offer discounts based on family size and annual income. Please complete the following information and return 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 Center. You must complete this form every 12 months or if your financial situation changes.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE : \_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Total Gross wages: Please include all salaries, tips, etc. Income from business and self-employment; 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 for all members of the household:

TOTAL INCOME INCLUDING ALL OF THE ABOVE FOR ALL HOUSEHOLD MEMBERS: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOTAL INCOME 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 (specify).

Income: Prior year tax return, two most recent pay stubs, or other Self-declaration of income may also be used.