Center of Hope
FOR BEHAVIORAL HEALTH

Sliding Fee Program Application

It is the policy of The Center of Hope for Behavioral Health to provide essential services regardless of a patient's ability to pay. The Center of Hope provides discounts based on family size and annual income.

Proof of income ***must accompany*** this application. If you do not have your proof of income, please keep this application and return with the proper forms. Proof of income can include your most recent federal income tax return, paycheck stubs (4 weeks required), most recent W-2 Forms, a letter of attestation, benefit letters or statements that show proof of what you receive for social security, unemployment, workers compensation, child support, etc. The discount will apply to all **essential** services (therapy and eligible case management services) received at this clinic, but not those services requested outside of the clinic including, court related activities, drug screens, and other such services. You must complete this form every 6 months or if your financial situation changes.

Date: _____ Name: _____ Date of Birth: _____

Telephone:_____

Address, City, State, Zip Code: _____

Employer: _____ Insurance:_____

Gross wages, salaries, tips, etc., of all taxable household income: _____

Please list names and birth dates of all family members that live in your household, including applicant:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that the Center of Hope for Behavioral Health receives federal funding and provides discounts to patients who qualify based on income and family size. I understand that these discounts are only for patients who meet eligibility criteria established by the Federal Government. I understand that if I qualify for discounted services, they will provide it to me as long as I continue to qualify. I agree to inform CHBH of any substantial change in my financial status that could prevent me from being eligible for the discount. I also agree to provide updated proof of income at future visits upon request. All patients can apply for the sliding scale fee program. However, discounts will only be applied after third party payments or assignments. I understand that I am responsible for all charges billed to me not covered by third party payors, and that CHBH may refuse to provide non-emergency services and may engage a collection agency to collect from me if I fail to make timely payments. Knowing their limitations, I hereby request discounted mental health services at CHBH. **I attest that all information, including the attached proof of income, is true and accurate.** CHBH provides for fees to be reduced or waived under special circumstances.

Applicant Signature: _____

OFFICE USE: Annual adjusted gross income: _____

Based on the above information, the applicant is eligible for a sliding fee adjustment of: _____%

Approved By: _____ Date: _____