ACCESS BEHAVIORAL HEALTH SERVICES

Sliding Scale Application

Please complete the following information to determine if you or members of your family are eligible for a discount. Discounts are offered based upon family income and size. Copies of tax returns, pay stubs and other information verifying income may be required before a discount is approved. The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including but not limited to; reference laboratory testing and medications.

In the hope that your financial situation improves, discounts apply only to current, not future services. It is the responsibility of the patient or parent/guardian, to inform this agency of any changes to income or household size and/or active insurance policies.

Number of related persons living in your household: [ ]

Household Member	Household Income (complete one column) **Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment and public aid.**		
	Annual	Monthly	Bi-Weekly
SELF			
SPOUSE			
DEPENDENT **Children under age 18**			
TOTAL			

I certify that the family size and income information shown above is correct.

Name: (print) ________________________________ Date: __________________________

Signature: _______________________________

Office Use Only

Approved Rates: Intake **Medication Management** **Counseling**

Approved By: **Date:**