



Family Guidance Center Sliding Fee Scale Application Form

Consumer Name: _____ New Consumer: Yes/No Date of Application: _____

Consumer's Date of Birth: _____ Consumer Age: ____ Consumer SSN (Optional): _____

Spouse's Name (if married): _____ Spouse's SSN (Optional): _____

If consumer is a child and/or disable:

Parent/Guardian # 1 Name: _____ Parent/Guardian # 1 SSN (Optional): _____

Parent/Guardian # 2 Name: _____ Parent/Guardian # 2 SSN (Optional): _____

List all who reside in your home that you are legally & financially responsible for:

	<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>	<u>Age</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

It is the policy of Family Guidance Center to provide health care services at a cost that is affordable to its consumers. The annualized incomes of the consumers' households must be calculated and documented in order to provide health care services at an appropriate fee, based on Family Guidance Center's Sliding Fee Scale and as mandated by rules governing Certified Community Behavioral Health Centers. This information may also assist Family Guidance Center to help consumers with other programs that offer financial assistance. If you are the parent or guardian of a minor or legal guardian of an adult, please provide your financial information. If married, please provide both incomes.

FAMILY GUIDANCE STAFF: Document sliding fee program eligibility by use of the Sliding Fee Eligibility Calculator Excel spreadsheet. This application, the Eligibility Calculator, and copies of income documentation used for screening must be entered into the consumer's file.

I attest that the income information I have provided to Family Guidance Center is true and accurate to the best of my knowledge. I understand that if I have been untruthful about my current income, I will become 100% liable for my Family Guidance Center charges and I will not be eligible for the sliding fee program during future visits. I further understand that my eligibility for the sliding fee scale program will be re-determined at least annually and that I must report any change in my income and/or household size to Family Guidance Center.

Signature of Consumer or Guardian

Date

Family Guidance Center Witness

Date

