**Logo

Description automatically generated**

**Sliding Fee Discount Information**

It is the policy of Integrity Mental Health to provide essential services regardless of the patient’s ability to pay. Integrity Mental Health offers 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 clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Head of Household | | | Place of Employment | |
| Street | City | State | Zip | Phone Number |

**Please list Spouse and dependents under the age of 18**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | DOB | Name | DOB |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | Self | Spouse | Other | Total |
| Gross wages, salaries, tips, etc |  |  |  |  |
| Income from business, self-employment, and dependents |  |  |  |  |
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement |  |  |  |  |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources |  |  |  |  |
| **Total Income** |  |  |  |  |

**NOTE:** Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

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

|  |
| --- |
| Printed Name |
| Signature |
| Date |

Office Use Only

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved Discount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Verification Checklist | Yes | No |
| Identification: ID/DL, Utility bill or employment ID |  |  |
| Income Verified: Taxes, one month of most recent pay stubs |  |  |
| Insurance: Insurance Cards |  |  |