Changing Lives at Home Inc.,
Mental Health Services

Discounted/Sliding Fee Application

Client Name ___________________________________ Date _________________

HOUSEHOLD INFORMATION
Please list below **all** members of your household, including yourself.

	Name	Relationship	DOB		Name	Relationship	DOB
1.		*self*		4.			
2.				5.			
3.				6.			

INCOME STATEMENT

Please list all sources of MONTHLY INCOME for the household:

	Amount	
Employment	________	
Unemployment Compensation	________	
Supplemental Security Income (SSI) – adults and children	________	
Social Security Disability Income (SSDI)	________	
Child Support Income	________	
Pension	________	**Total Gross**
Social Security	________	**Monthly Income****
AFDC	________	______________
Other	________	

****Please provide verification of income (check stubs, income tax returns, social security statement, etc.)**

INSURANCE INFORMATION (Please bring relevant card to your appointment)

Do you have health insurance? No Yes #________________________
Do you have Medicaid? No Yes #________________________
Do you have Medicare? No Yes #________________________

I certify that all the information is true and complete. I understand that verification of income is required in order to receive a discounted rate.

___________________________________ ___________________________
Signature of Client (or Parent or Guardian) Date

Changing Lives at Home Mental Health Services' reduced fees are based on a person's ability to pay for services. "Ability to pay" is based on household income. A reduced fee on the sliding scale is available to clients who are unable to pay the full fee for outpatient therapy service.