PEOPLE INC
People Helping People

Sliding Fee Discount Application

It is the policy of People Inc.'s Youth and Family Services department to provide essential behavioral health services regardless of the patient's ability to pay. Discounts are offered 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 do not include services received at other clinics or departments within People Inc.

This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, Public Assistance, Veterans' Payments, Survivor Benefits, Pension or Retirement Income				
Interest, Dividends, Rents, Royalties, Income from Estates, Trusts, Educational Assistance, Alimony, Child Support, Assistance from outside the household, 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.

Name (Print) _____

Signature _____ Date _____

Office Use Only

Patient Name: _____

Approved Discount Amount: _____

Approved By: _____ Date: _____

Verification Checklist	Yes	No
ID/Address: Driver's License, Utility Bill, Employment ID, etc.		
Income: Prior Year Tax Returns, 3 Most Recent Pay Stubs, Other		
Insurance: Insurance Cards		