POCS Mental Health, P.C. Sliding Fee Scale Application

Patient Information			Today's Date: / /		
First Name:	Middle:	Last:	Other names:		
Home Address:		City:	State:	Zip:	
Mailing Address:		City:	State:	Zip:	
Home Phone #: ( ) -		Home Phone #: ( ) -			
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No		
Marital Status:	Single	In a relationship	Married	Divorced	Separated Widowed

Household Size		
Name	Date of Birth	Social Security Number
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income			
Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	$

NOTE: To comply with federal regulations, in order to give you a discount on our mental health services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Sliding Fee Scale:

A – 80% Discount

B – 60% Discount

C – 40% Discount

D – 20% Discount

E – 0%Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform POCS Mental Health, P.C. if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of POCS Mental Health, P.C. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:________________ Name (Print):______________________________

Signature:______________________________

POCS MENTAL HEALTH, PC
SLIDING FEE SCALE AGREEMENT

We are pleased to offer a sliding fee schedule for those who qualify. Please read the following and sign below indicating your agreement to these terms.

1. I understand that the fees for mental health services are based on gross annual household income and family size.
2. I understand and agree that payment is due when services are rendered unless an arrangement has been made in advanced.
3. If i have an unpaid balance when I terminate services, I agree to make monthly payments until the balance is paid in full.
4. I agree to pay the full amount of my session fee if I cancel any appointment without giving a minimum of 24 hours notice.

Household Family Size	Annual Houshold Income
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120

For families/households with more than 8 persons, add $4,480 for each additional person.

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Client's Signature

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Date