familysolutions
commitment . compassion . community

SLIDING FEE DISCOUNT APPLICATION

Head of Family Information: _____

Number of people living at home: _____

Family Member Information – Family Includes Self, Other Household Earner, and children under age 26

Name	Date of Birth	Employed
1.		Yes/No
2.		Yes/No
3.		Yes/No
4.		Yes/No
5.		Yes/No
6.		Yes/No
7.		Yes/No

I HAVE provided the following sources of income verification with the application (select one):

- The last 2 paycheck stubs for each adult working in the household.
- A statement from employer (signed, dated on company letterhead) stating rate of pay, average number of hours worked per week, and hire date for each adult working in the household.
- Unemployment benefit letter.
- Social Security benefit letter showing current monthly payment
- Last (current year) federal tax returns, quarterly tax statement if self-employed.
- Verification of Workers Compensation Insurance benefits.
- Military family allotment verification.
- Payment made from trusts or estates verification.
- Documentation of child support (divorce papers, letter from Recovery Services)
- Copy of pension/ retirement benefits.
- Documentation of State support
- 1040 or W-2 statement due to loss of employment.
- Self-declaration of income may also be used.
- **I HAVE NOT SUBMITTED ANY SOURCES OF INCOME VERIFICATION AND UNDERSTAND THAT I HAVE (5) FIVE BUSINESS DAYS TO BRING IN INCOME VERIFICATION OR I WILL BE BILLED FOR THE FULL COST OF SERVICES RENDERED.**

I understand if I qualify for the Sliding Fee Discount Program, the fee charged for services will be dependent upon the level of discount provided. I understand I must apply for the Sliding Fee Discount Program every 12 months. I understand that I must list all family members and wage earners in my family and provide income verification to be eligible for the Sliding Fee Discount Program. I give Family Solutions staff permission to contact my employer or any other appropriate source to verify. I authorize Family Solutions to bill my insurance carrier for services rendered by our providers.

I agree to pay for all charges not paid by my insurance company or charges not covered by financial assistance as determined by this application. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney's fees.

I understand that if any of this information has been falsified to fraudulently receive services, my participation will be revoked, and I will be responsible for 100% of the usual and customary charges of Family Solutions. I will notify Family Solutions of any changes in my health insurance status or any of the above information.

_____ _____

Signature Date