



**Sliding Fee Discount Application**

It is the policy of River Valley Counseling Center to provide essential 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 not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. 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**

Revised December 1, 2016

| 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 income     |      |        |       |       |
| Interest, dividends, rents, royalties, income from, estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources |      |        |       |       |
| <b>Total Income</b>   |      |        |       |       |

**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:** \_\_\_\_\_

**Approved by:** \_\_\_\_\_

**Date Approved:** \_\_\_\_\_

| Verification Checklist  | Yes | No |
|---|-----|----|
| Identification/Address: Driver's license, utility bill, employment ID, or other |     |    |
| Income: Prior year tax return, three most recent pay stubs, or other            |     |    |
| Insurance: Insurance Cards  |     |    |