Wabi Sabi Behavioral Health Center

Sliding Fee Discount Program Application

It is the policy of Wabi Sabi BHC to provide essential services regardless of the patient's ability to pay. Wabi Sabi BHC offers discounts based on family size and annual income. Please complete the following information and return it 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 purchased from outside, including reference laboratory testing, drugs, and other such services. You must complete this form every 12 months or if your financial situation changes.

Name				
Last	Last		М	
Address				
Street	City	State	Zip Code	
Contact				
Email			Phone	

Please list all household members, including those under age 18.

	Name	Date of Birth
Self		
Other		

Please list all sources and amounts of income for your household.

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
Total Income			

I certify that the family size and income information shown above is correct.

Name	
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 identification, or other						
Income: Prior year tax return, three most recent pay stubs, or other						
Self-declaration of income						