The Village Family Service Center
Sliding Fee Discount Program Application

It is the policy of The Village Family Service 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 office. This form must be completed every 12 months or if your financial situation changes.

Name of Head of Household ______________________________

Address/City/State/Zip ______________________________

Place of Employment ______________________________

Phone # / Zip Code ______________________________

Please List Spouse & Dependents Under Age 18

	Name	**Date of Birth**
Self		
Spouse		
Dependents		

Annual Household Income

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, veteran's 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/or 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 above information is correct. I understand that willful misrepresentation may jeopardize continued services at The Village Family Service. In addition, I agree to provide updated financial information to The Village in the event that it changes, so that counseling fees may be adjusted accordingly. I also agree to pay my reduced counseling fee prior to each scheduled appointment. If payment is not made prior to each scheduled appointment, no future appointments will be made until payment is made.

______________________ ______________________ __________

Print Name Signature Date

Counselor Completion

The client treatment plan requires _____ sessions for ____ weeks. The recommended fee, based on current financial information is: $_________/session.

____

Counselor Signature Date

____

Clinical Supervisor Signature Date

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, W-2, or other	____	____
Insurance: Insurance Cards	____	____