Sliding Fee Scale Discount Application Form

Client's Name: _____ New Client: Yes/No Date of Application:_____

Client Date of Birth:_____ Client Age:_____ Client ID Number: _____

Spouse's Name (if married):_____

If client is a child and/or disabled:

Client # 1 Name:_____

Guardian # 1 Name:_____

Client # 2 Name:_____

Guardian # 2 Name:_____(If applicable)

List all who reside in your home that you are legally & financially responsible for:

Name	Relationship	Date of Birth	Age

It is the policy of FCC Behavioral Health to provide health care services at a cost that is affordable to its clients. The annualized incomes of the clients' households must be calculated and documented in order to provide health care services at an appropriate fee, based on FCC Behavioral Health's Sliding Fee Scale/Nominal fee and as mandated by rules governing CCBHC Community Behavioral Health Centers. This information may also assist FCC Behavioral Health to help clients with other programs that offer financial assistance. If you are the parent or guardian of a minor or a legal guardian of an adult, please provide your financial information. If married, please provide both incomes.

FCC Behavioral Health Staff: Document sliding fee program eligibility by use of the Sliding Fee Eligibility Calculator Excel spreadsheet. This application, the Eligibility Calculator, and copies of the income documentation used for screening must be scanned into the client's file.

I attest that the income information I have provided to FCC Behavioral Health is true and accurate to the best of my knowledge. I understand that if I have been untruthful about my current income, I will become 100% liable for my FCC Behavioral Health charges, and I will not be eligible for the sliding fee program during future visits. I further understand that y eligibility for the sliding fee scale program will be re-determined at least annually and that I must report any change in my income and/or household size to FCC Behavioral Health.

_____ _____

***Signature of Client or Guardian** **Date**

_____ _____

FCC Behavioral Health Witness **Date**

***Must have guardian paperwork in the client's file if a guardian signs.**

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