**JUNIPER TREE COUNSELING -** **Sliding Fee Discount Application**

It is the policy of Juniper Tree Counseling to provide essential services regardless of the patient’s ability to pay. Juniper Tree Counseling offers discounts 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. You must complete this form every 12 months or if your financial situation changes.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |
| --- | --- | --- |
|  | Name | Date of Birth |
| Self |  |  |
| Other |  |  |
| Other |  |  |
| Other |  |  |
| Other |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Income Source (s)** | **Self- Indicate Amount Earned** | **Other(s)- Indicate Amount Earned** |  **Total** |
| Gross wages, salaries, tips, etc. |  |  |  |
| Income from business and self-employment |  |  |  |
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivorbenefits, pension or retirement income |  |  |  |
| Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside thehousehold; and other miscellaneous sources |  |  |  |
| **Total Income** |  |  |  |

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print 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 ID, or other |  |  |
| Income: Prior year tax return, three most recent pay stubs, or other |  |  |

 Self-declaration of income may also be used.

**Sliding Scale:** 