Appendix C: Sliding Fee Scale Application Form

COLUMBIA COMMUNITY MENTAL HEALTH

Clients Name: _____

Responsible Party (if different from client):_____

Address: _____

Street City State Zip

Day Phone: _____ Cell Phone:_____

Client's date of Birth: _____

Do you currently have health insurance? Yes_____No_____

Name & phone # of insurance company: _____

Insurance I.D. #_____

Number of people living in household: ☐

Client Name:	AGE	Employed Y / N	FT or PT	Relationship to client Client
Responsible party: (if different from client)		Y / N		
Dependant:		Y / N		
Dependant:		Y / N		
Dependant:		Y / N		
Dependant:		Y / N		

Please enter **GROSS monthly** income for the **CLIENT/RESPONSIBLE PARTY/SPOUSE/DEPENDANTS**

PROOF OF INCOME IS REQUIRED

Source of Income:	LAST MONTH Self	LAST MONTH Other	LAST 3 MONTHS Self	LAST 3 MONTHS Other
☐ None				
Wage/Salary	$	$	$	$
OSIP - State	$	$	$	$
Alimony/Child Support	$	$	$	$
Social Security	$	$	$	$
Public Assistance	$	$	$	$
SSI	$	$	$	$
Pension/Unemployment/Vets	$	$	$	$
Other	$	$	$	$
Dividends/Interest	$	$	$	$

TOTAL INCOME:_____

∗Please make additional comments about your household's financial circumstances that may affect your ability to pay for treatment:_____

_____

_____

- ***"I understand that by signing below I am attesting to the accuracy of the information in this form and authorize CCMH to verify any and all information on this application.***
- ***I understand that falsifying any information on this form or in the supporting documentation I provide will result in re-evaluation of my request for a reduced fee, and possible disqualification.***
- ***If it is determined that I have received services for a reduced fee using information I know to be false, I will be responsible for the full fees for these services.***
- ***Should any of my financial information change, I understand that it is my responsibility to inform CCMH immediately so that my information can be updated and so that my eligibility can be re-evaluated.***
- ***I understand that not all services offered at CCMH are eligible for the sliding scale discount."***

Responsible Party's Signature_____

Date:_____

FOR OFFICE USE ONLY Acct # _____

Gross Income: _____ # in household _____

Qualified for discount: YES NO % Rate: _____

Beginning Date: _____ Expiration Date: _____

Financial Office Notes

OHP Checked ☐

Gave OHP Application Information (How to Apply)☐

Bad Debt:_____

Profiler/Credible Balance:_____

Notes:_____

_____

_____

Processing Admissions Specialist: _____Date:_____

Financial Office Approval: _____ Date: _____