FEE ASSESSMENT

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: [ ]

	AGE	Employed	FT or PT	Relationship to client
Client Name:		Y / N		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		LAST 3 MONTHS	
	Self	**Other**	**Self**	**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:____

____

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- ***"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:
COBAL:____
OHP:____
Bad Debt:____
Profiler Balance:____
____
____
____

Processing Account Specialist: _____________________________Date:_______________

Financial Office Approval: ______________________________ Date: ______________