CAROLINA BEHAVIORAL
HEALTH AND WELLNESS

SLIDING SCALE FEE APPLICATION

Patient Name (First, Middle, Last): _____ Date of Birth: _____

Mailing Address: _____ Phone: _____

City, State, Zip: _____ SS#: _____

Total in Family Unit: _____ Number of Adults _____ Number of Children _____

Do you have Health Insurance or Medicaid? YES _____ NO _____ If yes, What type? _____

SOURCES OF INCOME FOR APPLICANT AND PERSONS IN THE FAMILY (Dependents)

***Applicant must provide documentation with the application. A list of appropriate documents is listed below. Provide the documents that are applicable to you and your family.

- **Applicant's Salary** - Provide at least one of the following as applicable to you:
  - **30 days of most recent pay statements** i.e. weekly (4), bi-wkly or semi-mthly (2) monthly (1)
  - Letter on letterhead from employer that states current hourly rate and normal number of hours in work week
  - If self-employed, provide your most recent tax returns including 1099 Schedule C
- **Other Family Member's Salary**: Provide at least one of the items required for the applicant's salary.
- If unemployed (either applicant or other family members), please provide:
  - Wage history (from Employment Security Commission) AND
  - Unemployment Wage Summary (from E.S.C.)
- Current statement for disability, social security, and/or pension showing monthly earnings
- Alimony and/or child support – Indicate amount paid or provide statement of monthly alimony and/or child support income.
- Worker's compensation benefits
- VA/pension income
- Public Assistance
- Food Stamp Verification
- **No source of income** - Provide us with a letter that supports your current financial status. This letter may ONLY come from a minister/priest/rabbi, director of a homeless shelter, landlord, or social/case worker.

Patient Name_____ **Date of Birth**_____

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POLICY

Carolina Behavioral Health & Wellness is dedicated to providing quality mental and medical services regardless of the patient's ability to pay. Carolina Behavioral Health & Wellness offers discounts based on family size and annual income.

The discount will apply to all services received at this office, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by consulting radiologist, and ither such services. You must complete the following form every 12 months or if your financial situation changes.

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Last 4 digits of Social Security Number:** _____

Do you have commercial health insurance, Medicare, and/or Medicaid? ☐ **Yes** ☐ **No** ☐ **Not Sure**

HOUSEHOLD

A "household" includes legal **children**, a civil union **partner** or married **spouse**, and legal **dependents**. Please list the name of individuals in your household and relation to you. Please use the back of this form for additional space.

Names of Individual living in household (including yourself)	Date of Birth
TOTAL number of people in household:	

ANNUAL HOUSEHOLD INCOME

Source of Income	Self	Partner	Other	Total
Gross wages, salaries, tops, etc				
Social Security (SSI or SSDI)				
Unemployment Benefits				
Investment Income				
Other				
TOTAL INCOME				

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

Name: (print) _____

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.