Children's Home Society of Idaho

SLIDING FEE DISCOUNT APPLICATION

Warm Springs Counseling Center offers a Sliding Fee Discount Program for clients and their families who may qualify for assistance with the cost of services. Warm Springs Counseling Center will base program eligibility on annual income and family size. WSCC does not discriminate on the basis of age, gender, race, sexual orientation, gender identity/gender expression, creed, religion, disability or national origin. Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule to determine discounted services.

CLIENT'S LAST NAME	FIRST	MIDDLE	DATE OF BIRTH
NAME OF HEAD OF HOUSEHOLD			
STREET ADDRESS	CITY	ZIP	TELEPHONE

Please list spouse and dependents under the age of 18

SPOUSE AND HOUSEHOLD MEMBER NAMES	

Annual Household income

Source	Self	Spouse
Gross wages salaries, tips.		
Income from self-employment		

Supporting documents can include Copies of Tax returns, W-2 form or other information verifying annual total household income is required before the discount is approved. Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. In the case of two parent households, each parent is required to provide proof of income.

Agreement

If awarded a discounted rate, the responsible party will be notified in writing. Discounted rates are based solely on income and family size and current Federal Poverty Guidelines. There may be a balance for each visit if not covered by insurance. If there is a financial hardship that makes paying any discounted rate difficult, the responsible party may contact Warm Springs Counseling Center about a payment plan or other options. Clients approved for a subsidy will have a limit on the amount of sessions to be determined by the clinician. Applicants have the option to reapply after 6 months has expired since the last discounted session or anytime there is a significant change in family income.

I agree to all of the Sliding Fee Discount program requirements. I understand that providing false information of any kind will result in immediate termination of this agreement and I will be required to pay the agency's full rate for each date of service provided. I certify that the family size and income information shown above is correct. I understand the client's responsible party is required to pay any balance at each visit.

Responsible Party _____

Name (Print)

_____ _____

Signature Date

Office Use Only

Approved Discount _____ **Date approved** _____

Executive Director _____

Clinical Director _____

Business Office Manger _____