A close up of a logo

Description automatically generated

**Sliding-Scale Fee Discount Information**

It is the policy of The PORCH Therapy Group to provide essential services regardless of the patient’s ability to pay. The PORCH Therapy Group offers discounts based on family size and annual income.

Please complete the following information and return to the therapist to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services received outside The PORCH Therapy Group. You must complete this form every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list spouse and dependents under the age of 18.**

|  |  |  |
| --- | --- | --- |
| **Family Info** | Name | Date of Birth |
| Self |  |  |
| Spouse |  |  |
| Dependent |  |  |
| Dependent |  |  |
| Dependent |  |  |
| Dependent |  |  |

**Please list all sources of income.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Self** | **Spouse** | **Other** | **Total** |
| Gross wages, salaries, tips, etc. |  |  |  |  |
| Income from business, self-employment and dependents |  |  |  |  |
| Unemployment compensation, workers' compensation, Social Security, SSI, public assistance, Veterans' Payments, Survivor Benefits, pension or retirement |  |  |  |  |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources |  |  |  |  |
| **Total Income** |  |  |  |  |

NOTE: Copies of tax returns, pay stubs and other information verifying income may be required before a discount is approved.

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that the family size and income information shown on page 2 of this application is correct.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_** (signature) (date)

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**Office Use Only**

**Patient Name:**

**Approved Discount:**

**Approved by:**

**Date Approved:**

|  |  |  |
| --- | --- | --- |
| **Verification Checklist** | **Yes** | **No** |
| **Identification/Address**: driver's license, other ID, utility bill |  |  |
| **Income:** prior year tax return, recent pay stub, other |  |  |
| **Insurance:** insurance cards |  |  |