

Worcester Youth and Family Counseling Services

Sliding Fee Discount Application

It is the policy of Worcester Youth and Family Counseling Services to provide essential services regardless of the patient's ability to pay. Discounts are therefore offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for this discount. The discount will apply to all counseling services received at this clinic. This form must be completed every 12 months or if your financial situation, and/or insurance situation changes.

Name of Head of Household: _____

Place of Employment: _____

Home Address: _____

Please list spouse and dependents under the age of 18.

	Name	Date of Birth
Self		
Spouse		
Dependent		
Dependent		
Dependent		
Dependent		
Dependent		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				

Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Total Income				

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

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, 3 most recent pay stubs, or other		
Insurance: Insurance Cards		