

Moore Peace Counseling & Wellness PLLC
Sliding Fee Discount Application

Client Information

Head of Household: _____

Number of People in Household: _____

Household Members Information-Household members include self, spouse/partner, and children under age

| | Name | Date of Birth | Relationship | Employed (Yes/No) |
|----|-------------|----------------------|---------------------|--------------------------|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ | _____ |

Income Verification (Select All applicable)

Please provide all applicable income:

- Last 2 paycheck stubs
- Most recent federal tax return
- Social Security benefits letter
- Unemployment benefits letter
- Child support documentation

Pension/retirement income

Other: _____

Important Agreement

- I understand that this application must be completed in full.
- I understand that I must submit income verification within **5 business days**, or I will be responsible for the full cost of services.
- I understand that eligibility is based on household income and size.
- I understand that this application must be renewed every **12 months**.
- I certify that the information provided is accurate and complete.
- I understand that if I qualify for the Sliding Fee Discount plan, an office fee may be charged for each visit depending on the service rendered.
- I understand that I must list all Household members and wage earners in my household and provide income verification to be eligible.
- I give Moore Peace Counseling & Wellness PLLC staff permission to contact my employer or any other appropriate source to verify.
- I authorize Moore Peace Counseling & Wellness PLLC to release all or part of my patient record to any person or organization.
- I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of medical insurance benefits be paid to Moore Peace Counseling & Wellness PLLC.
- I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection fees.
- I understand that if any of this information has been falsified to fraudulently receive services that my participation will be revoked, and I will be responsible for 100% of the usual and customary charges of Moore Peace Counseling & Wellness PLLC.
- I will notify Bailey's Counseling Service, PC. of any changes with my insurance, income or any of the above information.

Authorization

I authorize Moore Peace Counseling & Wellness PLLC to verify the information provided and contact relevant sources if necessary.

Signature: _____

Date: _____

Office Use Only:

I confirm that the client has completed the Sliding Fee Discount Application in full. Household size and income have been verified based on the supporting documentation provided. Based on this information, the client's total income is \$_____, calculated on a _____ (bi-weekly, monthly, or annual) basis. The client has been approved for the Sliding Fee Discount Program, with eligibility effective through _____ (12 months from the date of application).