AppState Psychology Clinic
Sliding Fee Scale Application

Please complete the following information and return to your clinician to determine if you are eligible for a discounted rate.

The discounted rate will apply to all services received at this clinic, but not outside services that may be recommended by your clinician. This form must be completed every 12 months or if your financial situation changes.

Client Name: ____

Date of Application: _____________________________________

For young adults (over 18 years old) in school:

- Do you have another family member(s) who will be paying for your services? ☐ Yes ☐ No
    - If yes, who? ____
- Are you financially independent from your family? ☐ Yes ☐ No

Note: We use tax guidelines to determine financial independence. These guidelines consider young adults who provide more than half of their own support *or* do not live at home anymore (living on campus or in a college apartment during the academic year does not count) to be financially independent. If you are financially independent from your family, please complete the chart below based on your own personal financial information. If you are not financially independent from your family, please use your family's financial information to complete the chart below.

Name of Head of Household			**Place of Employment**	
Street	**City**	**State**	**Zip**	**Phone**
Estimate of Annual Household Income:				

Household Members	
Name	**Date of Birth**
Self	
Spouse	
Dependent	
Dependent	
Dependent	
Dependent	

Please note that documentation of income is required prior to sliding scale approval. If you are not financially independent for tax purposes, as described above, please provide documentation of your family's financial information. Please indicate below the documentation that you are providing:

____Tax Return/ FASFA (preferred)

____W2 before taxes (for all caregivers/financially contributing members if patient is a minor or dependent)

____Pay Stubs (for all caregivers/financially contributing members if patient is a minor or dependent)

____Other ______________________

I certify that the family size and income information shown above is correct to the best of my knowledge.

____ ______/______/________

Name (print) Date

____

Signature

For Office Use Only

Decision and Justification:

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____ ______/______/________

Clinician Name (print) Date

____

Clinician Signature

____ ______/______/________

Supervising Psychologist Name (print) Date

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Supervising Psychologist Signature