rivervalley behavioral health

SERVICE LOCATION:
COMPLETE PAYOR SEQUENCE:

SLIDING FEE DISCOUNT PROGRAM APPLICATION FORM

CLIENT NAME:_____ **Client ID #:** _____

RESPONSIBLE PARTY NAME:_____

ADDRESS: _____

PHONE #:_____

Please list all household members, including those under age 18.

	Name	Date of Birth
SELF		
OTHER		
OTHER		
OTHER		
OTHER		

ANNUAL INCOME: **(Income verification must be attached to form)**

SOURCE	SELF	OTHER	TOTAL
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
TOTAL INCOME			

I certify that the family size and income information shown above is correct.

_____ _____

Applicant Signature **Date**

THIS SECTION FOR INTERNAL USE ONLY

CLIENT NAME/CLIENT ID: _____

CURRENT SELF-PAY BALANCE: _____

EXPLANATION FOR REDUCTION: _____

_____ _____

Business Office Signature **Date**

THE BUSINESS OFFICE MUST SEND THE FEE REDUCTION REQUEST FORM AND ANY ATTACHED DOCUMENTATION TO THE FINANCE DEPARTMENT AT THE REGIONAL OFFICE IN OWENSBORO. THE FINANCE DEPARTMENT WILL APPROVE OR DENY THE REQUEST AND RETURN SUCH REQUEST TO THE BUSINESS OFFICE.

Reduction Request: ❑ **APPROVED,** ❑ **DENIED**

Fee Reduction Effective Until: _____

Approved Discount: _____

Fee Reduction Denied due to: _____

_____ _____

C.F.O. Signature **Date**

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment identification, or other		
Income: Prior year tax return, three most recent pay stubs, or other		