SLIDING FEE SCALE

Program Application

10/21

INTRODUCTION

The Family Counseling Center offers a reduced charge for services called a **Sliding Fee Scale**. To qualify for this program, you must document your household income and expenses, be denied medical coverage by Medicaid, have no other medical coverage or have a high deductible on your insurance plan. **Reduced charges can range from 0% to 80% of the actual charge.**

If you have questions, or think you are eligible for reduced charges, please call or make an appointment to speak with a Billing Representative (*see number below*).

It is suggested that individuals who do not have health insurance apply for Medicaid or meet with a Health Insurance Navigator.

Only completed applications will be processed.
For questions or if you are having difficulty completing the application, please call or email our Billing Department at **billing@thefamilycounselingcenter.org** or **518.725.4310 ext. 325**.

Please return the completed form to:
The Family Counseling Center
Attn: Billing Department
11-21 Broadway
Gloversville, NY 12078

OFFICE USE ONLY

Approved Discount: _____ Date Approved/Not Approved: _____

Payment Plan Comments: _____

_____

_____

Approved/Not Approved By: _____

THE FAMILY COUNSELING CENTER

SLIDING FEE SCALE

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SECTION 1: PERSONAL INFORMATION

Please Print

Applicant Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____ Email: _____

Place of Employment: _____

SECTION 2: DEPENDENTS

List spouse and dependents under the age of 18

Please Print

Name	Date of Birth

Spouse: _____

Dependent: _____

Dependent: _____

Dependent: _____

Dependent: _____

Dependent: _____

SECTION 3: ANNUAL HOUSEHOLD INCOME

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

SOURCE	SELF Amount	SPOUSE Amount	OTHER Amount	TOTAL Amount
Gross wages, salaries, tips, etc.				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support assistance from outside of the household, and other miscellaneous sources				

	SELF Amount	SPOUSE Amount	OTHER Amount	TOTAL Amount
TOTAL				

SECTION 4: CERTIFICATION

I certify that the information shown above is correct.

Name (Print) : _____

Signature : _____ Date: _____

Client Name (If different than above) : _____