

Life & Purpose Behavioral Health

APPLICATION FOR SLIDING FEE

CLIENT # \_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial \_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

County of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Size: \_\_\_\_\_ Family Income: \_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTACH PAST TWO MONTHS’ OF PAY STUBS OR COPIES OF INCOME STATEMENTS**

Medicaid # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (no charge for services)

Insurance Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved for Sliding Fee: YES\_\_\_\_\_ NO\_\_\_\_\_\_

Consumer and Life & Purpose Behavioral Health agree to sliding fee of \_\_\_\_\_\_\_\_% of normal and customary service rates. Consumer agrees to notify L & P Services of any change in income.

Consumer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Life & Purpose BH Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_