Sliding Fee Discount Program Application

Head of Household Information

- **Name:**
- **Date:**
- **Contact Information:**
  - Address:
  - Phone Number:
  - Email Address:

Family Size & Income Information

1. **Family Size (**Please list all family members including yourself)

Name	Age	Relation

2. **Income Information**
   - Please provide your household's total income. Include income from all sources and for all household members.

   Income Sources and Frequency

   - **Employment:** _____
     - Employer Name: _____
     - Gross Income (before taxes): _____
     - Frequency of Income:
       - ☐ Weekly
       - ☐ Biweekly (every two weeks)
       - ☐ Monthly

Yearly Conversion of Income

- To accurately determine your eligibility for the sliding fee discount program, please follow the guidelines below to convert your income.
    - **Weekly Income –** Gross Income: _____ x 52 =_____
    - **Biweekly Income –** Gross Income: _____ x26 =_____
    - **Monthly Income –** Gross Income: _____ x12 =_____

- **Other Income**
    - **Source:**

☐ Social Security Income / Disability ☐ Unemployment benefits ☐ Other: _____

- **Weekly Income –** Gross Income: _____ x 52 =_____
- **Biweekly Income –** Gross Income: _____ x26 =_____
- **Monthly Income –** Gross Income: _____ x12 =_____

Self-Attestation of Income

I certify that I am unable to provide proof of income documentation currently. I understand that this information will be used to determine my eligibility for the sliding fee scale program.

Reason for not providing proof of income (check one):

- ☐ Recently unemployed
- ☐ Informal / non-documented work
- ☐ Lost or unable to obtain documentation
- ☐ Other (please explain): _____

Signature and Certification

- I certify that the information provided on this form is true and correct to the best of my knowledge. I understand that providing false or incomplete information may result in denial or loss of eligibility for the sliding fee scale program. I also agree to notify Centennial Mental Health Center within 30 days of any changes to my household income or household size.

- Signature: _____
- Date: _____

For Office Use Only

- **Application reviewed by:** _____ **Date:** _____
- **Approved by:** _____ **Date:** _____
- **Eligibility determined:**
  - ☐ Eligible
  - ☐ Ineligible
- **Notes:**

Is the client a CO resident and requesting Centennial's Med Services? If yes, please have them fill out the PBM Application. (Client must be eligible for the sliding fee and not have Medicaid.)