Hope Crossing Christian Counseling
Application for Reduced Fee Services

Client Name: _____ Year: _____
Last, First, MI

Social Security Number: _____-_____-_____ **Date of Birth**___/___/___ M__ F__

Address: _____ Apt. Number: _____
Street Number, Street Name

_____
City, State, Zip

Phone Numbers :(_____) _____-_____ **Number in Household:** (including self) _____

Total Household Income: $_____/month **Total Assets: $**_____

Listed Monthly Expenses: Rent/Mortgage: $_____ Utilities: $_____

Groceries: $_____ Car Payment: $_____ Car Insurance: $_____

Medical Expenses: $_____ Child Care $ _____

Other (explain): _____

Credit Card Company_____ Balance: $_____

Credit Card Company_____ Balance: $_____

Credit Card Company_____ Balance: $_____

I certify that the above information is true and correct and I am the responsibility party for payment of services rendered to **Hope Crossing Christian Counseling**. I have accurately completed the application and have agreed to participate in the **Sliding Scale Payment Plan** paying the assigned fee at the time of delivery of services, providing **Hope Crossing Christian Counseling** with either the front page of my IRS form or two current paystubs, and verifying that I either do not have insurance coverage or I am ineligible for insurance reimbursement. This fee will be re-evaluated each year when the new Federal Guidelines are available or if financial status changes.

Signed: _____ Date: ___/___/___

Expires: ___/___/___

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For Office Use Only

Total Assets/12: $_____ + Total Monthly Income: $_____ = $_____ (a)

Total # in House x $50: $_____ + Monthly Expenses: $_____ = $_____ (b)

(a) $_____ - (b) $_____ = $_____

Qualifies for _____$ Discount

I understand my fee will be discounted by $_____.

The fee will be due at the time of each session and will be re-evaluated each year when the new Federal Guidelines are available or if financial status changes.

Signed:_____ Date:____/____/____

Expires: _____/_____/_____