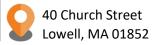
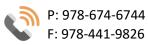


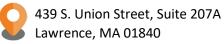
VINFEN BEHAVIORAL HEALTH

SLIDING FEE DISCOUNT PROGRAM APPLICATION

1. CLIENT INFORMA	TION				
Name:	Date of Birth:				
Address:					
City:	State:			ZIP:	
Daytime Telephone:	: ()		Do you h	nave insuranc	ce? Yes □ No □
Marital Status: Singl	le 🗌 Married 🗌 Divo	rced 🗆 Sep	parated \square Wide	owed \square	
Are vou employed?	Yes □ No □ If "Ye	es". Employ	ver:		
		Please list <u>yc</u>	ourself, significa		ouse, dependents, and others.
NAME	RELATIONSHIP	DATE OF BIRTH	INCOME SOURCE*	AMOUNT	FREQUENCY
	Self			\$	Weekly \square Monthly \square Yearly \square
				\$	Weekly ☐ Monthly ☐ Yearly ☐
				\$	Weekly ☐ Monthly ☐ Yearly ☐
				\$	Weekly ☐ Monthly ☐ Yearly ☐
				\$	Weekly Monthly Yearly
				\$	Weekly Monthly Yearly
				\$	Weekly ☐ Monthly ☐ Yearly ☐
By signing below, I affirn I agree that any mislea discount program, inclu provide additional infor program such as W-2, 1	m that the information ding or falsified information ding adjustment of feat mation/documentation 1040 tax forms, current requests. I understand	n provided he mation, and e or termination for the punt pay stuber that my no	nerein is comple d/or omissions ation from the p urpose of deter s, bank stateme ominal/discount	ete and accura may affect m program. I und mining my eli ents etc., and ted fee is due	mony, Interest, Investments, Other. ate to the best of my knowledge y participation in the sliding fee derstand that I will be required to gibility in the sliding fee discoun- agree to comply with all Vinfer each visit. I will inform Vinfen o yearly.
I further understand a not affect the quality o	_		•	•	status, and my ability to pay wil Health.
Client/Guardian (if applicable) Signature:					Date:
					EFFECTIVE DATE: January 2022









P: 978-674-6744 F: 978-681-9654