Vinfen
Behavioral Health

VINFEN BEHAVIORAL HEALTH

SLIDING FEE DISCOUNT PROGRAM APPLICATION

1. CLIENT INFORMATION

Name: ____**Date of Birth:** ______________________

Address: ____

City: ___________________________________ **State:** _______________________ **ZIP:** _____________

Daytime Telephone: (___) ______________________ **Do you have insurance?** Yes ☐ No ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Are you employed? Yes ☐ No ☐ **If "Yes", Employer:** ____

2. HOUSEHOLD/FAMILY INFORMATION: Please list yourself, significant other, spouse, dependents, and others.

NAME	RELATIONSHIP	DATE OF BIRTH	INCOME SOURCE*	AMOUNT	FREQUENCY
	Self			$	Weekly ☐ Monthly ☐Yearly ☐
				$	Weekly ☐ Monthly ☐Yearly ☐
				$	Weekly ☐ Monthly ☐Yearly ☐
				$	Weekly ☐ Monthly ☐Yearly ☐
				$	Weekly ☐ Monthly ☐Yearly ☐
				$	Weekly ☐ Monthly ☐Yearly ☐
				$	Weekly ☐ Monthly ☐Yearly ☐

* *Wages, Social Security, Public Assistance, Retirement/ Pension, Food Stamps/SNAP, Child Support, Alimony, Interest, Investments, Other.*

By signing below, I affirm that the information provided herein is complete and accurate to the best of my knowledge. I agree that any misleading or falsified information, and/or omissions may affect my participation in the sliding fee discount program, including adjustment of fee or termination from the program. I understand that I will be required to provide additional information/documentation for the purpose of determining my eligibility in the sliding fee discount program such as W-2, 1040 tax forms, current pay stubs, bank statements etc., and agree to comply with all Vinfen rules, regulations, and requests. I understand that my nominal/discounted fee is due each visit. I will inform Vinfen of any changes in my income and understand that I may be asked to reverify my income yearly.

I further understand and acknowledge that my sliding fee discount application, its status, and my ability to pay will not affect the quality of care received nor my access to services at Vinfen Behavioral Health.

Client/Guardian (if applicable) Signature: ________________________________ **Date:** ___________________

EFFECTIVE DATE: January 2022