Innovative
COUNSELING PARTNERS

Sliding Fee Scale Application

NOTE: To comply with federal regulations and give you a discount on our behavioral health services, it is necessary to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income once a year. A copy of your most recent paycheck stubs, copies of your social security benefit letter, or other income verifications will be sufficient proof.

First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Phone Number			Date of Birth:	

	Name	Date of Birth Month/Day/Year	Health Insurance	Relationship	Patient at ICP?
Household Members					

	Weekly/ Bi Weekly/Monthly	For YOU	For Children	For Other	Subtotal
	Gross wages, salaries, and tips				
	Social security & pensions				
	Annuity & veteran benefits				
	Child support & alimony				
	Self-employment & Other				
				TOTAL	

Verification of income is mandatory. By signing below, I agree that Innovative Counseling Partners, PLLC may contact each employer of all persons working in the above mentioned household and/or may contact various agencies to verify any source of income. Within 5 days, I will provide ICP with a copy of all requested information, as listed, for all persons in the above mentioned household.

I will be asked to reapply for the SFS every year so ICP can maintain an updated SFS application on file. I am obligated to inform ICP of any change in household size, income, and/or insurance. I am also obligated to provide NMC with any income information that is requested. Applications lacking required information will be denied without notice after 5 days.

I verify that all Information provided on this form is true and correct. Fraudulent self-reporting on any portion of this application may jeopardize your status at ICP/or punishable by law.

Signature:	Date:
Name Printed:	