Northern Psychiatric Associates

Discounted/Sliding Fee Application Form

It is the policy of Northern Psychiatric Associates to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the clinic to determine if you are eligible for a discount.

The discount will apply to all services received at this clinic. In the hope that your financial situation improves, discounts will be applied for twelve months of services from the approval date. At that time the application form must be completed. Therefore, the application is good for a period of one year, then patient needs to reapply.

Number of persons living in your household: _____

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children under age 18			
Total			

*Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment and public aid.

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's License, Birth Certificate, Employment ID, Social Security Card or Other		
Income: Prior years tax return, Page 1 or three most recent pay stubs.		
Insurance: Insurance Card(s)		
Medicaid: Application made or evidence of rejection		

I certify that the family size and income information shown above is correct. Copies of page 1 of previous years tax return or pay stubs will be required before a discount is approved.

Name (Print) _____ Date: _____

Signature _____

Office Use Only			
Patient Name		Discount	$
Patient DOB		Approved by	
Date the Application is valid			