Sliding Fee Program Application

Spectrum Optimal Care, LLC

Please complete the following information. When turning this in, please provide proof of income through 2 most recent pay stubs, two most recent bank statements, and the most recent income tax return.

Client Information		**Today's Date: / /**		
First Name:	Middle:	Last:	Other Names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Cell Phone #: ( ) -		*Circle one* Home / Work Phone #: ( ) -		
Date of Birth: / /		Social Security # - -	Do you have insurance? __Y __ N	
Marital Status:	__Single __In a relationship __Married __Divorced __ Separated __Widowed			

Household Size		
Name	**DOB**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income (employment)			
Name	**Amount**	**Frequency (circle one)**	**Employer**
	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

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Other Income					
Source	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Child Support					
Alimony					
Interest Income					
Other:					
				Total	**$**

Note: To comply with federal regulations, in order to give you a discount on our services, it is necessary to ask you some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income, at least once every 12 months. ***Your yearly income tax return, the two most recent bank statements, and the two most recent pay stubs, and other income you receive will be sufficient proof.*** *Self-employed individuals will be required to submit details of the most recent three months of income and expenses for the business. Please attach all required documentation to this application, prior to submission.*

I _____ (client/guardian) do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may result in termination of services and legal action for reimbursement of services provided with false information.

Print Name _____ Date _____/_____/_____

Sign _____ Print name if guardian _____

To be completed by Admin			
Effective Date:	/ /	Renewal Date:	/ /
Print Name:		Signature:	