eunoia counseling

REDUCED FEE APPLICATION

It is the policy of Eunoia Counseling to provide essential mental health services regardless of the patient's inability to pay. Eunoia Counseling offers discounts based on family size and annual income.

Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount for mental health services.

The discount will apply to all services received at this clinic or through telehealth, but not those services or equipment purchased from outside, including psychiatric consult, psychological testing or psychological testing interpretation and other such services. You must complete this form every 12 months or if your financial situation changes.

Name of Head of Household: _____

Place(s) of Employment: _____

Home Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Please list self, spouse and dependents under the age of 18.

Name	Relationship	Date of Birth
Ex. Jon Doe	Self	1/1/1980
Ex. Jane Doe	Spouse	1/1/1984
Ex. Janet Doe	Dependent	1/1/2020
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		

(7)		
(8)		

Source(s) of Income	Self	Spouse	Other	Total
Gross wages, Salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income				
Interest, dividends, rents, royalties, income from Estates, trust, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				

Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print)_____

Signature_____ Date_____

OFFICE USE ONLY

VERIFICATION CHECKLIST	**YES**	**NO**

Identification /Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance cards		

Patient Name: _____

Approved Discount:_____

Approved by: _____ **Date of Approval:** _____