josselyn

Affordability Fee Program

Client/Applicant Name:_____Client Status:_____New_____Current Date: _____

Address:_____ Client ID#: _____

Phone:_____Email:_____ DOB: _____

Reason for the Request:

Income Verification:

Household Income: _____ Number of Dependents: _____

Documentation Requirements: (attached documents to the registration application)

- Valid ID (required)
- W2
- Two most recent pay stubs
- Federal tax return (Form 1040) for the last calendar year
- Self-Declaration of Income: _____ Client Signature: _____ Date: _____
- Other: Explain _____

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify Josselyn Center ASAP of change. I understand that I will be financially responsible for all or a portion of my care and that I will be asked to submit payment at the time of service. I authorize the release of any information necessary to establish myself/family for affordability scale.

Client/Applicant Signature	Print Name	Date
Employee Signature	Print Name & Title	Date

For Office Use Only

Approved by Director of RCM:_____ Date:_____ Approved_____ Denied _____

Affordability Fee Scale Amount/ Services Approved

_____ Initial Assessment _____ Individual/ Family Therapy _____ Group Therapy _____ IOP

_____Case Management/ Community Support _____ Psychiatric Evaluation _____ Medication Monitoring