Counseling Services of Bemidji

Sliding Fee Discount Application – Pg. 1

Counseling Services of Bemidji is dedicated to providing quality and accessible care to our patients. **No patient will be denied access to services due to inability to pay.** There is a discounted/sliding fee schedule available based on family size and income. You must complete this document in full to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Counseling Services of Bemidji, part or all your account balance may be forgiven.

In addition to a completed application, please provide the following:

- A copy of your most recent Federal Income Tax Return (Form 1040), including all applicable schedules, **or** an IRS Verification of Non-Filing Letter (if applicable).
- Documentation for **all applicable sources of household income** reported on this application. A list of acceptable income documentation is provided later in the application.

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation along with any pertinent changes.

Once we have reviewed your application, we will notify you of our decision in writing within 30 business days of receipt. If your financial situation has changed since you submitted your original application, you can submit an appeal within 30 days of the date on your determination letter.

Eligibility will be re-evaluated at least every 12 months. Patients are responsible for notifying the clinic if there is a significant change in household income, family size, employment status, or insurance coverage that may affect eligibility.

If you have concerns or would like to inquire about an appeal, please contact the office of Counseling Services of Bemidji at 218-382-1140. If you continue to have concerns that have not been addressed, you may contact the MN Attorney General's Office at (651)296-3353 or (800)657-3787.

This Application may be mailed to our office at 403 4th St NW Suite 315, Bemidji, MN 56601 or Faxed to 218-828-2137.

Patient Name:_____

Patient Date of Birth: _____

Spouse's Name: _____

Spouse's Date of Birth: _____

Marital Status (please select one): Single ___ Married ___ Divorced ___ Widowed ___

Street Address:_____

City: _____ State:_____ Zip Code:_____

Patient Phone Number:_____ Spouse Phone Number:_____

Counseling Services of Bemidji

Sliding Fee Discount Application – Pg. 2

Please list all dependents in your household. Include each individual's date of birth.

_____

_____

_____

_____

Insurance Information (Please chose one):

Have Insurance____ Uninsured_____ Cost Share_____

If employed, how long have you been at your place of employment? _____

How much of your bill can pay per month? _____

Please complete the table below. Do not include non-cash assistance such as SNAP, WIC, housing assistance, and energy assistance is not included.

Self	Monthly Gross Income	Spouse
$	Gross Income/Unemployment/Work Comp	$
$	Social Security/SSI/SSDI	$
$	Self-employment	$
$	Retirement/Pension/Annuities/Veteran's Benefits	$
$	Child Support/Spousal Support	$
$	Other Re-occurring Income: _____	$
$	**Total Income (Please provide proof of all income)**	$

Any information you would like considered. Please attach an additional sheet if necessary. :

_____

_____

_____

_____

_____

_____

Please check applicable documentation that is included:

☐ Most Recent Federal Income Tax Return (Form 1040) or IRS Verification of Non-Filing (if applicable).

☐ Two (2) Most Recent Pay Stubs for Each Wage Earner (if applicable).

☐ Social Security, Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI) Award Letter (if applicable).

☐ Documentation of Self-Employment Income (if applicable).

☐ Retirement, Pension, or Annuity Benefit Statement (if applicable).

☐ Veterans Benefits Award Letter (if applicable).

☐ Unemployment or Workers' Compensation Benefit Statement (if applicable).

☐ Child Support or Spousal Support (Alimony) Documentation (if applicable).

☐ Documentation of Other Recurring Household Income (please specify):

_____

Assignment of Rights (Please Read Carefully)

By signing below, I certify that the information provided on this application is true and correct to the best of my knowledge. I certify that I have submitted documentation for all sources of income reported on this application. I understand that all information and supporting documentation will be kept confidential and used solely to determine eligibility for the Sliding Fee Discount Program. I understand that incomplete or missing information or documentation may delay or prevent the review of my application, and that Counseling Services of Bemidji may request additional documentation to verify my eligibility. I understand that submission of this application does not guarantee approval or financial assistance.

Name (Print): _____ Signature: _____ Date: _____

Spouse (Print): _____ Signature: _____ Date:_____