

SOUTHERN IOWA MENTAL HEALTH CENTER SLIDING FEE SCALE APPLICATION

		Social Security #:							
			Birth:						
Date of Application:									
First Name:	Middle Name:	Las	t Name:						
Address:									
	State: Z								
Home Phone:	Cell Phone:								
Are you currently covered u	nder any Health Insurance plan?:	○Yes	○No						
If yes, what is the name of th	ne plan?:			_					
Gross Monthly Income Deta	nils:								
Number of adults in househo									
Number of children in house									
Currently Employed: Ye									
,	9								
					-				
○ Full-Time ○ Part-Tir	ne () Seasonal () Other	r:							
Source		Self	Spouse	Other	Total				
Gross wages, salaries, tips, etc.									
Unemployment compensations,	workers compensation, social security								
Income, public assistance, vetera	ans' payments, survivor benefits, pension	ı							
or retirement income									
Interest income, dividends, rent,	royalties, income from estates, trusts,								
educational assistance, alimony,	child support, assistance from outside								

the household and misc. sources

		I	I		1					
Total Income										
Proof of Income may be required with this application including but not limited to pay stubs, tax returns, etc.										
I certify that the family size and income information shown is correct:										
Name:	_ (Print)	Date:								
Signature:	_									
	OR OFFICE USE ON									
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Yearly GROSS family income:	# Persons in house	ehold	_ =	%PGL						
DETERMINATION OF ELIGIBILITY										
Eligible for assistance	Not Eligible fo	r assistance								
% of Fee due from client%	% of Fee due f	rom grant	%							
Effective Date: Expiration Date:										
Authorizing Signature:		Date:								
When form is completed:										
Original scanned into Chart and emailed to	Angie with approv	al informatio	n							
Alert put in Credible and Iowa DHS Block Grant added as insurance										
Client notified by staff Date:	_ Staff initials:									