



**SOUTHERN IOWA MENTAL HEALTH CENTER**  
*SLIDING FEE SCALE APPLICATION*

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Application: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Are you currently covered under any Health Insurance plan?:  Yes  No

If yes, what is the name of the plan?: \_\_\_\_\_

**Gross Monthly Income Details:**

Number of adults in household: \_\_\_\_\_

Number of children in household: \_\_\_\_\_

Currently Employed:  Yes  No

Place of Employment: \_\_\_\_\_

Full-Time  Part-Time  Seasonal  Other: \_\_\_\_\_

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Unemployment compensations, workers compensation, social security income, public assistance, veterans' payments, survivor benefits, pension 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				

