



## Northwest Neurobehavioral Health, LLC Discount Fee Policy Application

It is the policy of Northwest Neurobehavioral Health, LLC (NNH) to provide essential mental health services regardless of the client's inability to pay. Discounts are offered based upon household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for four (4) months, after which the client must reapply.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all mental health services received at this clinic, but not those services for which you may be referred. Please notify us immediately if your financial situation changes. Payment for discounted services is expected at the time of service.

**Number of related persons living in your household:** \_\_\_\_\_

**Total household income:** Complete one column

Household Member	Household Income <b>Annual</b>	Household Income <b>Monthly</b>	Household Income <b>Bi-Weekly</b>
Self			
Spouse			
Dependent children under age 18			
<b>TOTAL</b>			

**Note:** Include income from all sources including gross wages, tips, social security, disability, Supplemental Security Income, survivor benefits, retirement income, interest, dividends, rents, income from estates, trustees, educational assistance, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, and Workers' Compensation (Housing subsidies and Food stamps do not apply)

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income will be required before a discount is approved. If not earning an income, please provide a brief statement explaining how living expenses are being covered.

\_\_\_\_\_  
**Name of responsible party (please print)                      Signature    Date**

\_\_\_\_\_  
**Name of Client if different than above (please print)**

<b>Office Use Only</b>	
Patient Name _____	Discount _____ Approved by _____
Effective Dates _____	Service _____
Provider _____	Accepted ___ Denied ___ Referred to: _____