



Associates for  
Psychiatric  
Services, P.C.

Associates for Psychiatric Services, PC will offer a Sliding Fee Discount Program to all who are unable to pay for their services. Associates for Psychiatric Services PC will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin.

The discount will apply to all services received at this clinic, but not those services that are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes

Be sure to give full information for everyone living in your home, and complete ALL sections of the application. If you don't return complete information your request can not be processed. All information will be confidential.

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.

If you have questions about the application, please do not hesitate to contact us at (712) 234-0220 ext. 11.

## COMPLETE ALL SECTIONS OF THE APPLICATION BELOW

### **1. Sliding Fee Discount Application**

**Fill attached form completely, please remember to sign the bottom of page two.**

### **2. Proof of Income for all members in your home:**

**Send Copies of all items below that apply.**

- Tax return/W2 for last year
- If you are employed: a pay stub with year to date income OR your last 3 pay stubs
- If you are self-employed: Balance sheet and Income Statement
- If you are unemployed: state unemployment claim AND final pay stub from last job
- Proof of denial benefits from Medicaid
- Monthly pension amount letter
- Disability income amount letter
- Social security income amount letter
- Proof of income from rent
- Proof of income from child support
- Proof of income from alimony
- If you have NO income written statement

### **3. Proof of Assets for everyone in your home:**

- Bank statements from the last 3 months
- Investment statements (401k, IRA, investment account, health savings account)



## SLIDING FEE DISCOUNT APPLICATION

NAME OF HEAD OF HOUSEHOLD		PLACE OF EMPLOYMENT		
STREET	CITY	STATE	ZIP	PHONE

**Please list spouse and dependents under age 18**

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	



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**Annual Household Income**

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

**NOTE: Copies of tax returns, pay stubs, bank statements or other information verifying income is required before a discount is approved.**

**I certify that the family size and income information shown above is correct.**

Name (Print)	
Signature	
Date	



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**Office Use Only**

Patient Name \_\_\_\_\_

Approved Discount: \_\_\_\_\_

Approved by: \_\_\_\_\_

Date Approved: \_\_\_\_\_

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Card		
Proof for Medicaid coverage application		