Western Mental Health Center
Sliding Fee Discount Application

It is the policy of Western Mental Health Center to provide essential services to residents of our five counties – Lincoln, Lyon, Murray, Redwood and Yellow Medicine regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. 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 applicable services received at this center, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if there is a change in your financial situation.

Head of Household			Place of Employment		
Street	City	State	County	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	

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				

***NOTE:** Copies of tax returns (most recent year), pay stubs (last month), or other information verifying income will be required before a discount is approved. Please attach copies of these items to the application to help determine eligibility.

I certify that the family size and income information shown above is correct. I understand that it is my responsibility to notify Western Mental Health Center of any changes in my income. I also understand discounts will be reviewed annually and at that time I may be asked to provide proof of income at that time. I understand that if I do not provide proof of income that any discounts will be revoked and I will be responsible for the full amount of charges.

Name (Print)	
Signature	**Date**

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 Cards		