Headway Emotional Health Services
APPLICATION FOR REDUCED FEES

Date: ______________________ Client ID:_______________

Client Name: ____

Phone Number: ________________________ County: __________________________

General Information:

Do you have insurance, HMO, other coverage for medical services? ( ) Yes ( ) No

Are you eligible for any medical/general assistance? ( ) Yes ( ) No

If yes, when did you apply?______________________

Are you eligible for Medicare/Medicaid coverage? ( ) Yes ( ) No

Do you: Own home ( ) Rent home ( ) Live with another ( )____________

Financial Information:

Income		**Deductions**	
Adjusted Gross Income From Tax form*:	____________	Hospital Bills:	____________
Spousal Support	____________	Child Support	
Child Support	____________	Paid by you:	____________
Interest/dividends:	____________		
Rental property income	____________	**Total**	
Pensions/Social Security	____________	**Deductions:**	____________
Disability pay:	____________		
Other Income:	____________	_____Number of Dependents (Including yourself and spouse)	
Total Household Income:	____________	**Total Adjusted Income:**	________________

*** Copy of most recent Income tax return form must be included with application to be considered.**

I certify this information is complete and accurate to the best of my knowledge. Any fraudulent statement voids this contract and results in responsibility for charges at full fee. **I am aware that the charges for my services are due at the time of service.** I understand that I will be charged the full fee of The Fail/Late policy if I do not cancel my appointments within 24 hours. I am aware that if there are any changes in the above information, it is my responsibility to update the information on the form to determine ongoing eligibility for reduced fees.

Responsible Party: ______________________________________ Date: _____________