PATH
Behavioral Healthcare

Request for Reduced Fees Sliding Fee Application

PATH Integrated Healthcare is committed to providing high-quality mental health services to all persons, regardless of their ability to pay. As such, we have developed a discounted sliding fee scale for our services. Please complete this form, so that we can determine your eligibility for discounted fees.

Name of applicant: _____

Name of service recipient (if not the applicant): _____

Address: _____

City/State/Zip: _____

Do you currently have insurance: ☐Yes ☐No

Do you need assistance applying for Medicaid? ☐Yes ☐No

How many people are in your family? (*you, spouse & children*) _____

What is your total gross annual household income? _____

Your signature below certifies that the information you have provided here is accurate to the best of your knowledge.

Applicant signature _____ Date _____

----------**FOR OFFICE USE ONLY**----------

Gross annual income :_____Proof of income:

Family Size % FPE % Discount

Completed by: _____ Date _____

NOTES:

PATH Integrated Healthcare does not discriminate in providing services or offering sliding fee scale rates to eligible individuals on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status.