CALISSA'S COUNSELING SERVICES

3580 Main St♦Building #11♦Suite E♦Hartford, CT 06112
Phone: (860) 778.5317♦ Fax: (860) 219-0100

Sliding Scale Application

Patient Information		Today's Date:	
First Name:	Middle:	Last:	
Home Address:	City:	State:	Zip:
Home Phone Number:	Cell Phone Number:	Email Address:	
Date of Birth:	Do you have Insurance? (Select one) ☐ Yes ☐ No		

Household Size	
Name	Date of Birth
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /

Household Income			
Name	Amount	Frequency	Employer
You	$	☐Weekly ☐Monthly ☐Yearly	
Spouse	$	☐Weekly ☐Monthly ☐Yearly	
Children	$	☐Weekly ☐Monthly ☐Yearly	
Other	$	☐Weekly ☐Monthly ☐Yearly	
Total	$	☐Weekly ☐Monthly ☐Yearly	

NOTE: To comply with federal regulations, to give you a discount on our mental health services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Only the family size and annual income will be used to determine your eligibility and calculate your discount.

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I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Calissa's Counseling Services, LLC if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Calissa's Counseling Services, LLC. I hereby acknowledge that I read the foregoing disclosure and understand it.

Name (Print): Date:

Signature: