Application for Reduced Fee Instructions: Fill out form COMPLETELY, sign, attach copies of all required documents	New Leaf Behavioral Health a nonprofit mental health organization

Client Name: ______________________ Date of Birth: ____________ ☐Child ☐ Adult (18 or older)

Gender: ☐ Male ☐ Female ☐ _________ Ethnicity: ____________ County of residence__________________

Parent/Guardian Name(s): ______________________ Relationship to client: ________________

Client's Current Address: ____
Street Address City State Zip

Parent / Legal Guardian Address: ____
(if different than above) Street Address City State Zip

Total Members of Household (include self): ______ Number of children in household: ______

HOUSEHOLD INCOME- For each person with income in the household, list income:			
Name:	1:	2.	3.
Date of Birth:			
Type of employment:	☐ Regular (full, part-time) ☐ Not employed ☐Other* ☐ Student*	☐ Regular (full, part-time) ☐ Not employed ☐Other* ☐ Student*	☐ Regular (full, part-time) ☐ Not employed ☐Other* ☐ Student*
Income from salaries, wages, tips, etc.	$ per	$ per	$ per
Income from contract work, self-employment	$ per	$ per	$ per
Social Security income	$ per	$ per	$ per
Veterans Admin benefits	$ per	$ per	$ per
Supplemental Security Income (SSI)	$ per	$ per	$ per
Alimony	$ per	$ per	$ per
Child Support	$ per	$ per	$ per
Retirement/pension	$ per	$ per	$ per
Unemployment Compensation	$ per	$ per	$ per
Workers Compensation	$ per	$ per	$ per
Student grants/stipends	$ per	$ per	$ per
Food Stamps, Section 8	$ per	$ per	$ per
Other:	$ per	$ per	$ per
Total Income	$ per	$ per	$ per

- Annual income must be used for **self-employed, contract, seasonal workers** & **unemployed**

Client/Responsible Person signature verifying accuracy of information included in this application and granting permission for information to be verified. **Omissions or falsification may deem client ineligible for reduced rate services. It is the client's responsibility for providing updates when income information changes.**

Print Name: ______________________ Phone Number: ________________

Signature: ______________________ Date: ______________________

Application for Reduced Fee 3725 National Drive, Suite 220, Raleigh, NC 27612 Tel: 919-781-8370 l Fax: 919-781-2266 l Email: info@nlbh.org	New Leaf Behavioral Health a nonprofit mental health organization

Client Name: ____ Date of Birth: ______________________

Eligibility criteria for reduced fee:

☐ No insurance
☐ Lapse in insurance with no means to extend coverage
☐ Insurance (but without mental health benefits)
☐ Insurance (with unaffordable insurance copay/copayment)
☐ Insurance (with unaffordable insurance deductible)

If insured, please list the following: Insurance Provider: ____

Subscriber ID: _________________ Copayment: ________ Coinsurance: ________ Deductible: ________

Address Verification (address must be verified by one of the above, please check and attach a copy)

☐ Driver's License ☐ Vehicle Registration ☐ Bank Statement
☐ Utility Bill ☐ Rental Agreement ☐ Other: _________________________

Proof of Income & Dependents: (check & attach) Must attach one of these items if you have earned income

☐ Federal Tax Form (e.g., Form 1040 or 1040EZ – most recent year)
☐ 2 Pay Stubs (most recent two)
☐ W-2 Form (most recent year)

Attach evidence of EACH of these types of income that you receive:

☐ Social Security income
☐ Veterans Administration benefits
☐ Supplemental Security Income (SSI)
☐ Alimony
☐ Child Support
☐ Retirement and pension payments
☐ Unemployment Compensation
☐ Workers Compensation
☐ Student grants/stipends
☐ Work First
☐ Food Stamps
☐ Section 8 Subsidies
☐ Other: ___________
☐ Other: ___________

If client or head of household is not employed and has no income, this must be verified by one of the following:

☐ Employment Security Commission Letter or company letter of separation.
☐ Letter completed by staff of social service agency, church, school, shelter, etc. Letter must be signed, dated, and include phone number.

All supporting documents must be received prior to first appointment. Acceptance into this program allows for counseling with one of our unlicensed therapists at a reduced rate.

Mail to: 3725 National Drive, Suite 220, Raleigh, NC 27612 **Fax to:** 919-781-2266 **Email to:** info@nlbh.org

For Office Use		
Date Application Received:	Date Information Verified as Complete:	
If insured, benefits verified (list benefits, dates of coverage):		
Number of Dependents	Annual Household Income	Consumer Fee
Approval Signature/Date		

Sliding Scale Opt-Out

If you would prefer to opt-out of our sliding scale fee determination process and instead have the flat fee of $40 per session, please complete just the following:

Please complete the first half of page 1 and skip the household income information section. Please skip all of page 2 and complete the following:

Choose one:

☐ I have no health insurance and am not on other programs like NC Medicaid or Healthchoice.

☐ I have health insurance but with a deductible or copay that is not affordable for me.

Please list insurance company: ______________________________

Insurance Policy No.: ______________________________________

Please list your copay per visit ___________ (or) deductible ________

☐ I have health insurance but have no mental health coverage.

Please list insurance company: ______________________________

Insurance Policy No.: ______________________________________

By signing below, I verify that information contained within this form is true. I understand that I will be able to complete the full Reduced Fee application to have my total household income determine a sliding scale fee and will qualify for a new rate for services for any sessions after that application has been completed, turned in and reviewed by NLBH staff.

Print Name: ___________________________ Signature: __________________________ Date: _________