

LIBERTY RESOURCES  
 BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES  
 1045 JAMES STREET  
 SYRACUSE, NY 13203

## Application for Sliding Fee Scale Program

A Sliding Fee Scale Program is available to all patients regardless of ability to pay. Completion of the application is needed to determine eligibility. Discounts and fees are based on current federal poverty guidelines. Approved Sliding Fee Scale applications will be honored for a 12 month period. Upon completion of the 12 month period, re-application is required.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ E-mail: \_\_\_\_\_

### Monthly Household Income:

Employment:	Disability:	Housing Allowance:
Self-Employment:	Social Security:	Military Family Allotments:
Child Support:	Unemployment:	Scholarships/Grants:
Spousal Support:	Public Assistance:	Training Stipends:
Pension Funds :	Food Stamps:	Allowance/Gifts:
Savings/Trusts (Income only):	VA Benefits:	Other:

**TOTAL Household Monthly Income** \$ \_\_\_\_\_

**TOTAL # of Household Members:** \_\_\_\_\_

### Attestation:

The information given is true and correct. I understand this information must be provided to qualify for sliding fee discount. I agree to notify Liberty Resources of any changes in my household income or family size. I understand that if approved, the sliding fee discount will be honored for a 12 month period and then requires re-application. I understand that a reduced rate is subject to review and approval by Liberty Resources.

\_\_\_\_\_  
 Applicant Signature

\_\_\_\_\_  
 Date

\*\*\*\*\*For Office Use Only\*\*\*\*\*

Sliding Fee Scale Reviewed by: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Sliding Fee Scale Approved (Y/N) \_\_\_\_\_

If denied, reason for denial: \_\_\_\_\_

Patient percentage of federal poverty guidelines per application: \_\_\_\_\_

Effective Sliding Scale Begin Date: \_\_\_\_\_

Effective Sliding Scale End Date: \_\_\_\_\_