Catalyst Behavioral Health shall provide essential services regardless of the client’s ability to pay for services rendered. Discounts are offered based upon family size and annual income. In order for us to determine eligibility for you and/or your family members, please complete the following application.

The discount will apply to all services rendered by Catalyst Behavioral Health and its contractors, but does not include those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services where applicable. This form must be completed at a minimum of every 12 months or more often as your financial situation changes.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Head of Household** | | **Place of Employment** | | |
|  | |  | | |
| **Street Address** | **City** | **State** | **ZIP** | **Phone** |
|  |  |  |  |  |

***Please list spouse and all dependents under age 18.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Name** | **Date of Birth** |
| Self |  | Dependent |  |
| Spouse |  | Dependent |  |
| Dependent |  | Dependent |  |
| Dependent |  | Dependent |  |

**Annual Household Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Self** | **Spouse** | **Other** | **Total** |
| Gross wages, salaries, tips, etc. |  |  |  |  |
| Income from business, self-employment, and dependents |  |  |  |  |
| Unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veteran’s payments, pension, or retirement income |  |  |  |  |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources |  |  |  |  |
| **TOTAL INCOME** |  |  |  |  |

***NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.***

ACKNOWLEDGMENT:

I, , certify that the family size and income information shown above is complete and accurate.

**Applicant Signature Date**

**Witness Signature Date**

**Office Use Only**

**Patient Name: Approved Discount:**

**Approved By:** **Approval Date:**

|  |  |  |
| --- | --- | --- |
| **Verification Checklist** | **Yes** | **No** |
| **Identification/Address:** Driver’s License, Utility Bill, Employment ID, other |  |  |
| **Income:** Prior year tax return, three most recent pay stubs, other |  |  |
| **Insurance:** Insurance cards |  |  |