The Jewish Board
Health and Human Services for All New Yorkers

Sliding Fee Application

Applicants Name: _____ Date: MM / DD / YYYY

Client ID Number: _____ Client Date of Birth: MM / DD / YYYY

Name of Clinic/PROS Program: _____ Person Assisting Applicant: _____

Insurance: _____

HSA/HRA Account: ☐ Yes ☐ No If Yes: Deductible Amount: _____

Co-Pay Amount: _____

Household Information

Name of Head of Household: _____

Place of Employment: _____ _____ _____ _____ _____

Street City State Zip Phone

For each person living in your household, please complete the following table:

Name	Age	Relationship*	Currently Employed?	
			Yes**	No
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

* Self, Spouse, Dependent, Other

** Please indicate Employment Information below:

Employment Information for each adult in household:

Name: _____ Date Started Working: MM / DD / YYYY

Employer or Business Name: _____

Type of Business: _____ Position / Title: _____

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Name: _____ Date Started Working: MM / DD / YYYY

Employer or Business Name: _____

Type of Business: _____ Position / Title: _____

Name: _____ Date Started Working: MM / DD / YYYY

Employer or Business Name: _____

Type of Business: _____ Position / Title: _____

Annual Household Income

Source of Income*	Self	Spouse	Other	Total
Income from business, self -employment and dependents				
Gross wages, salary, overtime, bonuses, tips, commissions (not included above)				
Unemployment Compensation				
Worker's Compensation				
Social Security Income				
Supplemental Social Security Income				
Veterans Payments				
Public Assistance				
Alimony and/or Child Support				
Interest, Dividends				
Rent for Owned Property				
Pension				
Support from Relatives				
Other: Please Explain _____				
_____				

*** Note: Please attach the following documents with this completed form:**
Last year's 1040 income tax form and two recent pay stubs for each employed person in your household

Attestation to Information provided above

I, _____, certify that the family size and income shown above is correct.

Signature: _____ Date MM / DD / YYYY

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This Section is for Office Use Only

Amount Charged for Consultation fee: $_____ Amount of current set fee $_____

This is:

	Please check if applicable	# Sessions Recommended Per Week
Initial Application	☐	
Treatment Plan	☐	
Family	☐	
Couple	☐	
Group	☐	
SFS Reapplication		
SFS Special fee review		
SFS Annual fee review		

Comments:

_____

_____

Name of Person Completing Application: _____

Site Location: _____

Signature: _____ Date MM / DD / YYYY

Name of Person Approving the Fee: _____

Signature: _____ Date MM / DD / YYYY

JBSFDP9022015