Crisis Preparation + Recovery

Sliding Fee Discount Application

It is the policy of Crisis Preparation and Recovery Inc., to provide essential services regardless of the client's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to determine if you are eligible for a discount.

The discount will apply to all services received with CPR, but not those services or equipment that are purchased from outside, including pharmacy, laboratory testing, drugs, x-ray interpretation by a consulting medical professional, and other such services.

The answers provided by the client and their family/household will be kept on file and in strict confidence. The client's eligibility is based solely on the basis of the patient's ability to pay (i.e income) and family/household size and does not discriminate on the basis of age, gender, race, creed, sexual orientation, disability, national origin, or legal presence/status.

This form must be completed every 12 months or if your financial situation changes.

CLIENT NAME			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

Health Plan/Insurance (if any):

_____

Please list spouse/partner and all dependents living in the home

SELF	DOB	DEPENDENT	DOB
SPOUSE/PARTNER	DOB	DEPENDENT	DOB
DEPENDENT	DOB	DEPENDENT	DOB
DEPENDENT	DOB	DEPENDENT	DOB

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, veterans' payments, survivor benefits, 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 (per year)				

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

I understand that I must requalify annually to maintain eligibility. Furthermore, I understand that I am responsible for 100% of any charges incurred prior to being deemed eligible to receive a Sliding Fee discount.

By signing below, I certify the family size and income information shown above is correct. If needed, I will provide supporting documentation.

_____

Signature Date

_____

Printed Name

FOR CPR USE ONLY
EFFECTIVE DATE:
EXPIRATION DATE: