BEHAVIORAL HEALTH SERVICES

INCOME VERIFICATION FORM

Clients who would like to apply for the sliding fee scale must declare their interest at the time of their visit. They must also fill out an income verification form and provide proof of income as described below. Income will be verified every 90 days and a new income verification form must be completed fully to apply for the sliding fee scale. If a client has a change in their income status, it is their responsibility to notify Behavioral Health Services at 307-688-5010 of that change.

Clients are required to give at least <u>one</u> of the following items as verification of income:

1. *Previous year tax returns (if unemployed)*
2. *Previous year W-2(If unemployed)*
3. *Current pay stubs (last 4 weeks if possible)*
4. *Lay-off notice from last employer (if unemployed)*
5. *Check stubs from Unemployment (last 4 if possible)*
6. *Child Support (if client is the child being seen for services)*
7. *Bank Statements or Statement of Monthly Income (if self employed, includes tips, or other wages not typically reported)*

Client Name:_____ Date of Birth:_____ Client Number:_____

Eligibility for the sliding fee scale is based on ***total household gross income*** . Please list all family members that are over the age of 18 and currently employed. If the client is unemployed, please list all sources of income including family members help with paying utilities, rent, food, and shelter for the client.

1. Family Member:_____ Total Gross Income:_____

   What bills/food/shelter are they helping out with?_____

2. Family Member:_____ Total Gross Income:_____

   What bills/food/shelter are they helping out with?_____

3. Family Member:_____ Total Gross Income:_____

   What bills/food/shelter are they helping out with?_____

Number of Family Members:_____ Monthly Payroll Amount: $_____

Payroll Frequency: ___Weekly ___ Bi-Weekly ____Semi-Monthly ____Monthly

Any Assistance Received in household?: *Food Stamps_____ *Medicaid____ *Disability___ *Medicare____

**(Need a copy of the card or disability letter if any are marked)*

I certify that all the above information is accurate to my knowledge and any false statements will terminate the sliding fee scale discount for my services with Behavioral Health.

Signature of Client: _____ Date:_____

Social Security Number:_____

Attach extra pages if necessary to include all family members and assistance received*

Updated 7/30/2018 TK