



for communication, behavior, and development

## Application for Financial Assistance

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Social Worker/ Care Attendant: \_\_\_\_\_ Phone: \_\_\_\_\_

The Emerge Center is a non-profit agency serving all people regardless of race, creed, ethnic origin, or level of income. The costs of services provided are based, to the greatest extent possible, on a person's ability to pay. To qualify for assistance, please fill in the information below. All information will be kept confidential.

The number of people living in your household \_\_\_\_\_. Their first names, ages, and relationships to you:

**Income:** *(Total for all members of the household)*

**Assets:**

Amount (Monthly/Yearly)	Type of Income	Current Value	Description
	Wages		Checking
	Social Security and SSI		Savings
	Pensions		CDs
	Disability		Money Market
	Alimony		Annuities
	Child Support		Stocks
	Welfare and Public Assistance		Bonds
	Interest		Life Insurance Cash Value
	Dividends		IRA/401(K)
	Capital Gains		Other Assets
	Other Income		
	<b>Total</b>		<b>Total</b>

We must have the following documentation to process your application (copies, not originals):

- \_\_\_ Pay stubs (last 2 months)
- \_\_\_ Last year's income tax return (if required to file)
- \_\_\_ 4 most recent bank statements for each account
- \_\_\_ W2 and 1099 forms
- \_\_\_ Proof of income that is not directly deposited (example: copy of social security check)

With my signature I agree that this information is true and correct and that I am responsible for any unpaid balance. If any of this information should prove to be knowingly misrepresented I will repay any fees reduced by this agreement. I understand that my continuing eligibility for reduced fees will be reviewed each year.

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

<b>ELIGIBILITY DECISION</b>
___ You are eligible to receive individual services at _____% of the full fee cost (minimum charge \$_____).
___ You are eligible to receive group therapy services at _____% of the full fee cost (minimum charge \$_____).
___ You are eligible for hearing aids at _____% of the full fee cost.
___ Your income exceeds our guidelines.