SELF-ATTESTATION FORM SLIDING FEE DISCOUNT PROGRAM
THEESEEDS Institute

THEESEEDS Institute is committed to making behavioral healthcare and skills training services accessible to all members of the community, regardless of financial ability. In alignment with our mission of empowerment and inclusion, we offer a Sliding Fee Discount Program for eligible clients. Discounts are based on household size and income and are designed to reduce financial barriers to care and training.

To qualify for the program, **clients must self-attest to their household income and size, and are required to provide verification within five (5) business days**. Changes in income or family size must be reported immediately. Services covered under this program are outlined in the Sliding Fee Discount Policy.

Patient's Name: _____ Date of Birth: _____
SS#: _____ Contact No.: _____
Application Date: _____ Email Address: _____

Household size refers to two (2) or more individuals who live together and are related by birth, marriage, or legal adoption, with one person recognized as the head of the household. For the purposes of the Sliding Fee Discount Program, household members are limited to immediate family only—this includes a spouse or partner, children, and other legal dependents. Dependents must be 19 years of age or younger to be counted in the household total.

Circle One: 1 2 3 4 5 6 7 8 9 Others: _____

Family Member Name	Social Security Number	Date of Birth

TOTAL FAMILY INCOME (MONTHLY)

Source	Self	Spouse/Partner	Other/s	Total
Gross wage, salaries, tips, etc.				
Social security, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self-employment, dependents				
Unemployment, worker compensation, strike benefits, etc.				
Rent, interest, dividend, royalty, other income				
Total Family Income				

Patient Declaration

I affirm that the information I have provided on this form is accurate and complete to the best of my knowledge. I understand that income verification is required to determine my eligibility for the Sliding Fee Discount Program.

I agree to promptly inform THEESEEDS Institute if there are any changes to my household income or family size, as these changes may impact my eligibility. I acknowledge that failure to report such changes may result in removal from the program and adjustment of any previously applied discounts.

I accept responsibility for any outstanding balances on my account and am aware that flexible payment options are available upon request.

_____ _____

Printed Name Signature/Date

_____ _____

Completed By Date of Expiration