Renewing Hope Family Counseling Center
24910 S. Las Brisas Road
Murrieta, CA 92562
Tel: 951-465-3664 **Fax:** 888-542-4042

Chart No._____

Clinic Location _____

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Applicant Name_____
Last First Middle Initial

Address_____
Apt. No. City Zip code

Social Security #_____**Home Phone No.**_____ **Cell Phone No.** _____

PLEASE LIST ALL MEMBERS IN YOUR HOUSEHOLD INCLUDING YOURSELF

BCHF MR No.	NAME	APPLICANT RELATIONSHIP	DATE OF BIRTH	DOES THIS PERSON HAVE HEALTH INSURANCE
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

TOTAL NUMBER OF FAMILY MEMBERS #

INCOME SOURCE – All members of the household must provide all sources of income.

Recent Tax Return | Worker's Compensation | Alimony | Unemployment/Disability | Employment Letter
Pay Check Stubs | Military/Veteran | Child Support | Public Assistance | In Kind Living Support
Self-Employment | Social Security | Pension/Retirement | Cash Gift/Temporary Support Letter | Other

NAME	SOURCE OF INCOME	FREQUENCY (WEEKLY, BI-WEEKLY, TWICE A MONTH, MONTHLY)	AMOUNT	(Office Use Only) TOTAL ANNUAL INCOME
			$	
			$	
			$	
			$	

TOTAL ANNUAL INCOME $

I certify that the above information is complete and correct. If any of the above information is false, untrue, misleading or incomplete, I understand that I may be required to pay full price for the services received according to the stablished fee schedule. By signing below, I give my consent to release any and all information from all sources needed to substantiate the above information.

Applicant Signature_____ **Date**_____

Chart No._____ Patient Name_____

FOR OFFICE USE ONLY

I certify that I asked the applicant/recipient about all sources of income received by the household before using this form, and that I made the best efforts to obtain all other possible sources of documentation. The information reported on this form and all attached documents were provided solely by the applicant/recipient. I did not modify the information in any way.

DOCUMENTS PROVIDED IN THE APPLICATION:

PROOF OF INCOME	☐ Profit & Loss (3 months)	☐ Alimony	☐ In Kind Donation of Room and Board
☐ Tax Return	☐ Public Assistance (Cal-Works)	☐ Child Support	☐ Cash Gift or Temporary Support
☐ W-2 Form	☐ Social Security (SSA, SSD,SSI,RSDI)	☐ Military family allotments	☐ Savings
☐ 1099 MIC.,1099 INT.	☐ Unemployment	☐ Royalties & Annuity payments	☐ Inheritance
☐ Pay check stubs	☐ Workers Compensation	☐ Interests & Dividends payments	☐ Sale of Property
☐ Employment Letter	☐ State Disability	☐ Income from rents	☐ Gifts Income
☐ Self Declaration of Income	☐ Pension/Retirement		

Calculation and Notes:

Family Size:	Total Gross Annual Household Income $	

Sliding Fee Level:	Nominal Fee $_____	Dental Fee $_____ Or %_____	Effective:	Expires:

Processed by	Date