Client Name (Last, First, MI) DOB

Parent/Guardian/Spouse Name Relationship

The fee for the initial assessment is $190. The fee for subsequent sessions is $150.00 per clinical hour and is due at the beginning of session. If other arrangements are needed, you should contact the clinician 24 hours prior to the session. In order to be considered for a reduced fee per financial need, please fill out the following information to the best of your ability.

1. What is the total household income claimed on last year’s taxes? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per month $\_\_\_\_\_\_\_\_\_\_\_\_
2. What is your total household take-home pay (including all adults in the home) as of today? Please attach copies of proof of income for the past two months. $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per month.

**Names of all individuals living in the household:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For more individuals please use the back of this form.*

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Income** Monthly Amount Name of Employer/Payor Name of Beneficiary

Wages/Salary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Wages/Salary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Child Support \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Retirement Benefits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Disability Benefits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Unemployment Benefits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Ability to Pay**

Amount earned if working \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total # in Household\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Dependants\_\_\_\_\_\_\_\_\_\_\_\_

Annual Income \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Income\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bi/Weekly Income\_\_\_\_\_\_\_\_\_\_\_\_

Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay/Deductible \_\_\_\_\_\_\_\_\_

I certify that the above information is correct and accurate to the best of my knowledge. I agree to notify Servicios de Esperanza of **ANY** changes to this information during the course of my/child’s treatment. I understand that failure to inform Servicios de Esperanza of any changes or false information will result in being billed for the full cost of services rendered. I understand that I have 30 days to appeal the fee amount determined and that a full review of my total financial situation will be conducted.

Per the information provided above, my monthly ability to pay for services will be **$**\_\_\_\_\_\_\_\_\_\_ per session, for every session received. This financial evaluation will be completed annually, or as my/child’s financial situation changes, whichever occurs first.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Signature of Client or Responsible Party Date Evaluated By Date