Servicios de Esperanza
Services of Hope

P.O. Box 1588
Muskegon, Michigan 49443
(231) 722-7980

Financial Intake

Client Name (Last, First, MI)_____ DOB_____

Parent/Guardian/Spouse Name _____Relationship_____

The fee for the initial assessment is $200. The fee for subsequent sessions is $180.00 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. 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 $_____
   -OR-
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:_____
3. _____ DOB:_____
4. _____ DOB:_____
5. _____ DOB:_____

For more individuals please use the back of this form.

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 Dependents_____
Annual Income _____ Monthly Income_____ Weekly Income_____

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 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 **$**_____ (to be completed by Evaluator) 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

Reviewed: 10/03/2023