INCOME VERIFICATION

(Completed upon admission and annually)

Last Name	First Name	Middle Initial	Date of Birth

Address	City	State	Phone Number

1. Are you employed? YES NO

   If yes, name of Employer: _____

   If yes, are you: Full-Time Part-Time Temporary Contractual

   If no, are you: Laid-Off Disabled Retired Unemployed

2. Please list yourself, significant other, spouse and qualified dependents living in your household:

Family Members Name	Relationship	Age	Date of Birth	Income Source	How Much
	Self				

My signature below attests that the information provided herein is complete and accurate. I understand that I will be required to provide additional information or documentation for the purpose of determining my eligibility in the sliding fee discount program such as W-2, current check stub, bank statement, etc. Failure to provide any necessary documentation may result in the entire amount of my services being billed to me. I agree to inform Community Mental Health and Substance Abuse Services of St. Joseph County of any changes of circumstance that may impact my eligibility. I understand that my nominal or discounted fee is due each visit.

Client Signature	Date	Authorized Signature	Date

OFFICE USE ONLY:

Family Size_____ **Household Income $**_____ **Annual Income $**_____