the emerge CENTER
for communication, behavior, and development

Application for Financial Assistance

Client Name: _____ Date of Birth: ___/____/_____
Responsible Party: _____ Relationship: _____
Address: _____
Phone #s: Home: _____ Work: _____ Cell: _____
Social Worker/ Care Attendant: _____ Phone: _____

The Emerge Center is a non-profit agency serving all people regardless of race, creed, ethnic origin, or level of income. The costs of services provided are based, to the greatest extent possible, on a person's ability to pay. To qualify for assistance, please fill in the information below. All information will be kept confidential.

The number of people living in your household _____. Their first names, ages, and relationships to you:
_____

Income: (*Total for all members of the household*) **Assets:**

Amount (Monthly/Yearly)	**Type of Income**	**Current Value**	**Description**
	Wages		Checking
	Social Security and SSI		Savings
	Pensions		CDs
	Disability		Money Market
	Alimony		Annuities
	Child Support		Stocks
	Welfare and Public Assistance		Bonds
	Interest		Life Insurance Cash Value
	Dividends		IRA/401(K)
	Capital Gains		Other Assets
	Other Income		
	Total		**Total**

We must have the following documentation to process your application (copies, not originals):
☐ Pay stubs (last 2 months)
☐ 4 most recent bank statements for each account
☐ Proof of income that is not directly deposited (example: copy of social security check)
☐ Last year's income tax return (if required to file)
☐ W2 and 1099 forms

With my signature I agree that this information is true and correct and that I am responsible for any unpaid balance. If any of this information should prove to be knowingly misrepresented I will repay any fees reduced by this agreement. I understand that my continuing eligibility for reduced fees will be reviewed each year.

Signature: _____ Date: _____

ELIGIBILITY DECISION
___ You are eligible to receive individual services at _____% of the full fee cost (minimum charge $_____).
___ You are eligible to receive group therapy services at _____% of the full fee cost (minimum charge $_____).
___ You are eligible for hearing aids at _____% of the full fee cost.
___ Your income exceeds our guidelines.

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