



APPLICATION FOR DISCOUNTED SERVICES

Any patient at the Nature's Edge Therapy Center who feels that their financial situation makes it a hardship to pay the full cost of their treatment may apply for discounted services. All application will be reviewed by the Board of Directors to determine eligibility. Determinations will be based on objective criteria that is outlined in the application.

Please be thorough as incomplete information may delay your application. Once you have completed the application please submit to Nature's Edge Therapy Center.

First Name: _____ Last Name: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____

Employer: _____ Monthly Gross Income: _____

Spouse's First Name: _____ Spouse's Last Name: _____
 Employer: _____ Monthly Gross Income: _____

Name and ages of dependants as would be listed on your Federal Income Tax form:

Name: _____	Age: _____	School/Employer: _____
Name: _____	Age: _____	School/Employer: _____
Name: _____	Age: _____	School/Employer: _____
Name: _____	Age: _____	School/Employer: _____
Name: _____	Age: _____	School/Employer: _____

Other Income:

- | | | | |
|---|-----------|----------|------------------------|
| 1.) Are you receiving Aid for Dependent Children? | _____ Yes | _____ No | Amount per Month _____ |
| 2.) Are you receiving Food Stamps? | _____ Yes | _____ No | Amount per Month _____ |
| 3.) Are you receiving Social Security Benefits? | _____ Yes | _____ No | Amount per Month _____ |
| 4.) Are you receiving Veteran's Benefits? | _____ Yes | _____ No | Amount per Month _____ |
| 5.) Are you receiving Child Support | _____ Yes | _____ No | Amount per Month _____ |
| 6.) Are you receiving Spousal Support | _____ Yes | _____ No | Amount per Month _____ |
| 7.) Are any of your children (living at home) employed? | _____ Yes | _____ No | Amount per Month _____ |
| 8.) Are you or your spouse receiving Unemployment Benefits? | _____ Yes | _____ No | Amount per Month _____ |
| 9.) Are you receiving any other additional income? | _____ Yes | _____ No | Amount per Month _____ |

Please Complete Monthly Budget Expenses:

Rent or House Payments _____	Automobile Payments _____	Monthly Medical _____
Insurance Premium _____	Doctor _____	Hospital _____
Utilities _____	Electric _____	Gas _____
Water & Sewer _____	Phone _____	Food _____
Clothing _____	Any other _____	Other _____

Total Monthly Expenses: _____

PLEASE INCLUDE WITH YOUR APPLICATION THE FOLLOWING:

- Copy of Payroll Stubs (for the last three months) _____ Applicant _____ Spouse
- Copy of most recent Federal Tax Return
- Unemployment Card and Check Stubs and Statements
- AFDC Check Stubs and Statements
- Documentation of other additional income

Total Monthly Income _____ Total Annual Income _____

This form is accurate to the best of my knowledge _____
Signature of Applicant Date