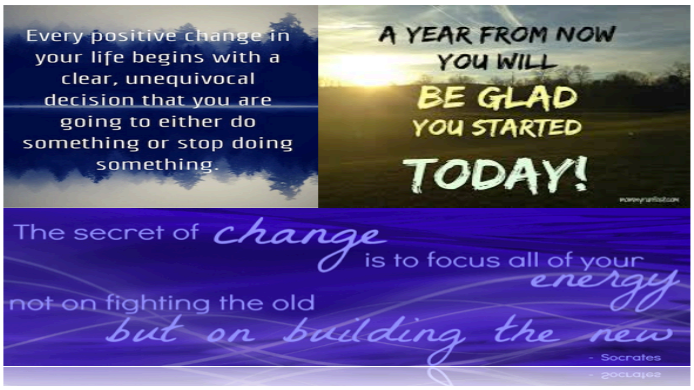

SLIDING SCALE REDUCED RATE APPLICATION

Sliding Scale rates are not retroactive. All supporting documents must be submitted with the application. Please book your appointment(s) after your application is processed in order to receive the reduced rate.

Reduced fee rates are for both counseling and hypnotherapy sessions

APPLICANT_____

Address_____ City _____

State_____ Zip_____ Phone_____

Employer_____ Employer Address_____

Health Insurance_____

Date of Birth_____ Hourly Wage $_____ Hours Worked Weekly_____

Annual Salary $_____ List all other income and amounts_____

_____

SPOUSE_____Employer_____

Employer Address_____

Health Insurance_____

Date of Birth_____ Hourly Wage $_____ Hours Worked Weekly_____

Annual Salary $_____ List all other income and amounts_____

_____

OTHER HOUSEHOLD MEMBERS (living in the same household)

Name_____ Monthly income or benefits $_____

Date of Birth_____ Relationship to applicant_____

Name_____ Monthly income or benefits $_____

Date of Birth_____ Relationship to applicant_____

Name_____ Monthly income or benefits $_____

Date of Birth_____ Relationship to applicant_____

Name_____ Monthly income or benefits $_____

Date of Birth_____ Relationship to applicant_____

Name_____ Monthly income or benefits $_____

Date of Birth_____ Relationship to applicant_____

***Include all sources of income: Wages, Social Security, Disability, Retirement, Veteran Benefits, Aid to Dependent Children, Rental Assistance, Child Support, Farm, Alimony, Self Employment, Rental Income, Interest, Dividends, etc.**

Source:_____

$_____

Source:_____

$_____

Source:_____

$_____

Monthly mortgage or rent $_____ Monthly Phone $_____

Do you own a vehicle? _____ Monthly Vehicle Payment $_____

Are you on any chronic medications? _____ Monthly expense$_____

Do you receive public assistance? _____

Other expenses to deduct: _____ $_____

_____ $_____ / _____ $_____

_____ $_____ / _____ $_____

_____ $_____ / _____ $_____

Any additional deductions / hardships to consider and amounts: _____

_____

_____

Please include a copy of your current income tax return and recent pay and/or benefit receipts/ award letters

I certify that all information and statements contained herein are true and correct. I understand that all information is confidential and a letter of determination will be mailed after processing. I understand that sliding scales rates and/or free services are not retroactive.

_____ _____

PRINTED NAME (FIRST) **PRINTED NAME (LAST)**

_____ _____

Signature **Dated**

*****(see the next page for sliding scale rate chart)**

MAIL APPLICATION AND PROOF OF ALL INCOME AND COPY OF CURRENT INCOME TAX RETURN TO:

Power of the Mind Holistic Healing Center
Dr. Sharon Jackson
103 South 3rd Street, Suite 102
Ozark, Missouri 65721

or scan and email to: powerofthemind@mail.com

SLIDING SCALE RATE CHART

FAMILY SIZE	LEVEL 1 $30.00 SESSIONS	LEVEL 2 $40.00 SESSIONS	LEVEL 3 $50.00 SESSIONS
1	$0 - $12,140	$12,141 - $16,753	$16,754 - $26,350
2	$0 - $16,460	$16,461 - $22,715	$22,716 - $32,150
3	$0 - $20,780	$20,781 -$28,676	$28,677 - $38,950
4	$0 - $25,100	$25,101 - $34,638	$34,639 - $44,750
5	$0 - $29,420	$29,421 - $40,600	$40,601 - $50,580
6	$0 - $33,740	$33,741 - $46,561	$46,562 - $56,060
7	$0 - $38,060	$38,061 - $52,523	$52,524 - $62,540
8	$0 - $42,380	$42,381 - $58,484	$58,485 - $68,020

Income levels are based on total GROSS family income, less child support payments made to another household, if any. For each additional family member over the household size of 8, add $4,320

***Reference: Federal Poverty Level Guidelines, 2019.