



# MARYLAND BEHAVIORAL HEALTH

## Sliding Fee Discount Program Application

(301) 249-8100 | marylandbhealth.com

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### Section 1: Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Section 2: Household Information

Total number of people in household: \_\_\_\_\_

Please list all household members:

Name	Age	Relationship	Annual Income

### Section 3: Household Income

Total annual household income (before taxes): \$ \_\_\_\_\_

Sources of income (check all that apply):

- Employment/Wages
- Self-Employment
- Social Security/SSI/SSDI
- Unemployment Benefits
- Child Support/Alimony
- Pension/Retirement
- Public Assistance (TANF, SNAP)
- No Income
- Other: \_\_\_\_\_

## Section 4: Documentation Provided

Please attach one of the following:

- Most recent federal tax return (Form 1040)
- Two most recent pay stubs
- Social Security/disability benefit letter
- Written statement from employer
- Self-declaration of income (if no documentation available)

## Section 5: Certification and Signature

I certify that the information provided on this application is true and accurate to the best of my knowledge. I understand that providing false information may result in termination of the discount. I agree to notify Maryland Behavioral Health if my household income or family size changes during the discount period.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Staff Use Only

Application Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

FPL Percentage: \_\_\_\_\_%

Discount Level: ■ Nominal ■ A ■ B ■ C ■ D ■ Denied

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_