

# GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER SLIDING FEE SCALE APPLICATION

**For Official Use Only:**

Submission Date: \_\_\_\_\_

Verification Date: \_\_\_\_\_

Medical Record Number:

#: \_\_\_\_\_

## SECTION A – APPLICANT INFORMATION

APPLICANT NAME:

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

SPOUSE'S / CL NAME:

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

CURRENT **MAILING** ADDRESS:

CURRENT **PHYSICAL** ADDRESS:

CURRENT PHONE NUMBERS  
(Home, cell, and other):

## SECTION B – FAMILY FINANCIAL STATUS

	APPLICANT	SPOUSE / COMMON LAW
OCCUPATION		
EMPLOYER		
ANNUAL GROSS WAGES OR SALARY, TIPS, AND INCOME FROM BUSINESS AND SELF-EMPLOYMENT	\$	\$

### OTHER SOURCES OF INCOME: (FOR APPLICANT, SPOUSE, AND DEPENDANT FAMILY MEMBERS)

SOURCE	TOTAL AMOUNT
PENSION OR RETIREMENT INCOME, DISABILITY, WORKERS COMPENSATION, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, UNEMPLOYMENT COMPENSATION, VETERANS' PAYMENTS, SURVIVOR BENEFITS	\$
ALIMONY, CHILD SUPPORT	\$
DIVIDENDS, INTEREST, ROYALTIES, GIFT, INHERITENCE	\$
INCOME FROM RENTAL PROPERTIES, ESTATES, AND TRUSTS	\$
ASSISTANCE FROM OUTSIDE THE HOUSEHOLD AND OTHER MISCELLANEOUS SOURCES	\$
<b>TOTAL INCOME</b>	<b>\$</b>

## SECTION C – DEPENDENTS

LIST THE NAME (S), DATE OF BIRTH, AND AGE (S) OF YOUR DEPENDENT(S)\*.  
\*CHILD(REN) UNDER 18 YEARS OLD ONLY. CHILD(REN) 18 YEARS OF AGE AND OLDER CAN APPLY SEPARATELY.

NAME:	DATE OF BIRTH: ____ / ____ / ____	AGE:
NAME:	DATE OF BIRTH: ____ / ____ / ____	AGE:
NAME:	DATE OF BIRTH: ____ / ____ / ____	AGE:

**SECTION D – PERSONAL STATEMENT**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ELIGIBLE FOR THE SLIDING FEE SCALE, I UNDERSTAND THAT THE DISCOUNT WILL BE APPLIED TO THE PORTION OF MY BILL THAT IS NOT COVERED BY MY HEALTH PLAN. I ALSO AGREE TO NOTIFY THE GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER WITHIN FIVE (5) WORKING DAYS OF MY CHANGE IN MY INCOME STATUS TO REASSESS MY ELIGIBILITY FOR THE SLIDING FEE SCALE PROGRAM. I AM INFORMED THAT I AM ABLE TO RENEW MY SLIDING FEE APPLICATION ANNUALLY (ONE YEAR FROM MY APPROVED APPLICATION DATE).

APPLICATION \_\_\_\_\_

DATE \_\_\_\_\_

**SLIDING FEE DOCUMENTATION NEEDED UPON SUBMISSION OF APPLICATION**

This is a Discount Program. Please provide the following:

1. Photo Identification of Applicant and Spouse (Driver's License, Guam I.D., any valid Passport, or work ID)
2. Prior Year Tax Return Filed with Guam DRT or three most recent check stubs for all working member (s) in the family, and any other documents of financial income (e.g. social security, alimony, and child support, etc.) indicated on this application.

**If applicant has NO FINANCIAL INCOME**, we need a letter of living arrangement from whoever is giving financial support to the applicant(s), and a verification of non-employment, or a certification of tax returns filed history from Guam DRT.

Note: **All documents must be copied** and turned in with application to be processed. **Any incomplete applications will delay the application process**. Any child(ren) 18 years or older can apply separately. If you have any questions, please contact the Patient Affairs Business Office staff at 647-5395/6.

**FOR INTERNAL OFFICE USE ONLY**

APPLICATION FOR SLIDING FEE SCALE IS  APPROVED FOR \_\_\_\_\_ % DISCOUNT

DISAPPROVED

FOR REASONS: \_\_\_\_\_.

STAFF \_\_\_\_\_

DATE \_\_\_\_\_

SUPERVISOR \_\_\_\_\_

DATE \_\_\_\_\_

APPLICANT WAS CALLED ON \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

NOTES: