Catholic Family Services
523 N. Duluth Ave Sioux Falls, SD 57104
(605)988-3775 fx: (605)988-3747

Sliding Fee Scale Application

Catholic Family Services offers discounted services to clients who do not have health insurance, cannot afford to pay full fee for services, or have insurance that doesn't cover certain services. Clients may apply for the Sliding Fee Scale Discount before or at their first visit.

CFS's sliding fee discount comes from the Foundation campaign known as Catholic Family Sharing Appeal (CFSA). Money is raised by individual Catholic parishioner's donating to the CFSA fund campaign each year. The CFSA monies raised come directly from parishioners from all over Eastern South Dakota; therefore we must be good stewards of this money.

1. Head of Household Information:

Name: (First, Last):	Social Security Number:	Date of Birth:	County:
Address:	City/State/Zip:	Home Phone:	Cell Phone:
# of people in the home:	Marital Status: Single Married Widowed Divorced Separated		

2. Income Information: Please complete for all adult household members who are employed: **Proof of Income** (Income Tax Return and/or last two paystubs) **must be provided** to CFS. Otherwise, services will be rendered at customary price.

Employed Person	Company Name	Income (Before Taxes)	Paid how often?
		$	
		$	
Other sources of income:	Alimony $	TANF $	Pension/Retirement $
Child Support $	Disability $	S.S.I $	Social Security $
Unemployment $	Other $	Other $	Other$

3. Household Information: List ALL individuals in household, including head of household.

Name:

1.	2.	3.
4.	5.	6.

4. Extenuating Financial Factors: CFS realizes that the entire scope of individual situations cannot be visualized through your income information alone. We would like to give you the opportunity to explain any extenuating financial factors that may contribute to your ability to pay.

_____

_____

_____

5. Proof of Income. Please be sure this form is turned in with your proof of income, tax return or last two paystubs. A sliding fee discount cannot be calculated with out these forms.

6. By signing below, I agree I will provide CFS with proof of income for the purpose of calculating my discount. I will be asked to reapply for the program on an annual basis. I agree to inform CFS if there are any changes to my income, household size or insurance coverage. I hereby certify that the information I provide is correct.

Applicant's Signature _____ Date _____

Guardian Signature _____ Date _____

Office use only

Verification Provided		Date	
30 days of check Stub		Gross Income	
Current tax return		Number of Dependents	
SS/Disability/Unemployment		Sliding Fee Amount	

Verification Provided		Date	
30 days of check Stub		Gross Income	
Current tax return		Number of Dependents	
SS/Disability/Unemployment		Sliding Fee Amount	

Verification Provided		Date	
30 days of check Stub		Gross Income	
Current tax return		Number of Dependents	
SS/Disability/Unemployment		Sliding Fee Amount	