West Bergen Mental Healthcare
Sliding Scale/Reduced Fee Application

West Bergen Mental Healthcare is a private, not for profit organization. The Agency is dependent upon fees which are generated by the cost of treatment services. West Bergen works with individuals who may have financial difficulties by using a sliding scale fee agreement for those who qualify.

Fee adjustments are based on a scale, which is developed by the Agency, and takes into consideration the number of individuals dependent upon the gross household income.

In order to apply for the sliding scale and determine eligibility for a fee reduction, you will need to provide us with the following documents:

- **Most recent IRS 1040 statement**
- **Two most recent pay stubs for each employed member of your household**
- **Court documented alimony/child support payments (if applicable)**

*All supporting documents and this application form must be returned together in order for your request to be processed.

Please fill out the following information to determine eligibility for a fee reduction:

Client Name: ___________________________________

Parent/ Guardian's Name (if minor): ___________________________________

Mailing Address: ____

Phone Number: _____________________________

Eligibility for a requested fee reduction will be determined within a week of receipt of documentation and fees are effective from the date of application.

Fees are reviewed periodically. At such time, you will be required to resubmit an updated application for review by West Bergen's Fee Committee. Please note that if you fail to provide the necessary documentation, your fee will remain set at full fee.

Your personal responsibility at the time of service is expected. This will help us to contain administrative billing costs. Unless we receive a 24-hour notice of cancellation, you will be charged a cancellation fee. Non-payment of three (3) successive sessions may be considered grounds for termination of treatment, unless prior arrangements have been made with your therapist.

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Signature of Client or Legal Guardian **Date**

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Please return all materials to your therapist or send to the following:

ATTN: Access Department
West Bergen Mental Healthcare
120 Chestnut Street
Ridgewood, NJ 07450
Fax: 201-493-1501

For additional information, please call (201) 444-3550

This form is also available for download on our website at www.westbergen.org

Internal Use Only

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Fee Set by Access: $______________

Access Clinician Signature: ____

Comments/Misc.:____