Boston Child Study Center

Expert Mental Health Treatment, Training, & Research

Application for Sliding Scale Fee

Today's Date:_____

Identifying Information:

Parent Name(s): _____ Phone: (_____) _____-_____ Email: _____

Home Street Address: _____ City: _____Zip:_____

Sliding Scale Service Fees:

Sliding scale fees are set based on three factors (listed below). Upon receiving this information, we will contact you to let you know if you qualify for reduced fees and what the reduce fee will be starting on the date you receive this message from our account manager. Note, the adjusted fee does not apply retroactively to services rendered prior to adjusting the fee. If you have any questions or concerns please contact our directors, Dr. Madigan and Dr. Lambright at (857) 400-9211.

1) **Total Family Income:** Current year:_____ Last year: _____
   Please attach documentation in the form of your most recent tax return to document the total family income figure above. We request and keep this information to ensure that fees are set in a consistent, fair, and reliable way for all families.

2) **Total # of Dependents:** _____

3) **Additional weekly/monthly mental health care costs:**

   (Note: this does not include cost of services covered by your insurance company).

Provider:	Name/Phone:	Fee:	Frequency (e.g. 1p/m, 1p/w):
Psychiatrist:	_____	_____	_____
Individual Therapist:	_____	_____	_____
Family therapist	_____	_____	_____
Case manager	_____	_____	_____
Other	_____	_____	_____

Please return this form to the Boston Child Study Center either in person or by:

Email: **AFlynn@BostonChildStudyCenter.com**

Mail: Boston Child Study Center, 729 Boylston Street, 5th Floor, Boston, MA 02116

Fax: (866) 496-3029