Boston Child Study Center

Expert Mental Health Treatment, Training & Research

Sliding Scale Form for Possible Fee Reduction

Today's Date:_____

Identifying Information:

Parent/Caregiver Name(s): _____ Phone: (_____) _____-_____

Email: _____

Home Address: _____ City: _____ State: _____ Zip:_____

Sliding Scale Service Fees:

Boston Child Study Center (BCSC) is dedicated to eliminating inequality in the mental health system by removing financial, discriminatory, and geographic barriers to high-quality, evidence-based treatment. Sliding scale fee reductions are one part of this mission and are available to families in need. Fees may be reduced to as low as $15 per session or $5 per session if a family receives 5 or more hours of services per week. Upon receipt of a completed form and accompanying documents, BCSC's underwriting team will review for a possible reduced rate. We will let you know if you qualify for reduced fees and what the reduced fee will be. Please note that, if you qualify, the adjusted fee does not apply retroactively to services rendered prior to receipt of the completed form and its accompanying documents. If you have any questions or concerns please contact Ashley Flynn at aflynn@bostonchildstudycenter.com.

1) Total Family Income: 2022 (estimate): _____ 2021: _____

Please attach documentation in the form of your 2 most recent tax returns and FAFSA documentation (if applicable) or any state or federal documentation demonstrating your family's financial status/need. We ask for the financial documents of all parents/caregivers regardless of the patient's age and/or financial independence, and caregivers' marital status. We may require supplemental documentation upon request. This form will be updated annually.

Financial Costs:

2) Total # of Dependents Claimed: _____

	School Name(s):	Annual Tuition:	Merit Aid:	Financial Aid:
3) Education Costs:	_____	_____	_____	_____
	_____	_____	_____	_____

4) Out-of-pocket weekly/monthly mental health care costs for any family member listed on the tax return (excluding BCSC services):

Provider:	Name & Phone Number:	Fee:	Frequency (e.g. 1x/mo, 1x/wk):
Psychiatrist	_____	_____	_____
Individual Therapist	_____	_____	_____
Family Therapist	_____	_____	_____
Case Manager	_____	_____	_____
Other	_____	_____	_____

Please return this form and attachments to Boston Child Study Center either in person, mail, fax: (866) 496-3029, or email: AFlynn@BostonChildStudyCenter.com