Autonomy Counseling, PLLC

Challenge. Determination. Success.

Sliding Fee Application

Autonomy Counseling, PLLC provides discounts to those needing essential services and having financial difficulties. Discounts are offered based on family size and annual income according to the federal poverty rate.

Please complete the following application to determine if you or your family members are eligible for a discount. The discount applies to all services received. This form must be completed every 12 months and any time your financial situation changes.

Name of Head of Household: _____

Place of Employment: _____

Address (city, state, and zip code): _____

Please list spouse and dependents under 18, and their date of birth:

Spouse: _____ DOB: _____

Dependent 1: _____ DOB: _____

Dependent 2: _____ DOB: _____

Dependent 3: _____ DOB: _____

Dependent 4: _____ DOB: _____

Dependent 5: _____ DOB: _____

Dependent 6: _____ DOB: _____

Dependent 7: _____ DOB: _____

Dependent 8: _____ DOB: _____

Annual Household Income

Gross wages, salaries, tips, etc.:

Self: _____ Spouse: _____

Other: _____ Total: _____

Income from business, self-employment, and dependents:

Self: _____ Spouse: _____

Other: _____ Total: _____

Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payment, survivor benefits, pension or retirement income:

Self: _____ Spouse: _____

Other: _____ Total: _____

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Interest, dividends, rents, royalties, income from estates, trust educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources:

Self: _____ Spouse: _____

Other: _____ Total: _____

Please list the total household income from all the sources: _____

By signing this form, I acknowledge that the information is true and correct.

*Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

Print Name: _____ Date: _____

Signature: _____

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