Hoxworth Counseling Services
Bret Hoxworth MA, LLP
126 E. Main Street, Suite B, Middleville, MI 49333 ◆ 269-205-2402 ◆ Fax:269-205-2728
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Application for Sliding Scale Fees

Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Place of Employment: _____

Number of family members living in household: _____

☐ Un-employed How long? _____

Reason for sliding scale fee?

_____

_____

_____

_____

Do you have other resources of support to help cover your counseling expenses (i.e., family members or church)?

☐ No ☐ Yes If yes, please explain: _____

Monthly Family Income (required)

☐ Client ☐ Spouse ☐ Other (responsible party): _____

Monthly Salary (gross): $_____

Public Assistance Benefits: ☐ Yes (please list all that apply) or ☐ Doesn't apply to me

Name: _____ Amount $_____

Name: _____ Amount $_____

Name: _____ Amount $_____

Un-employment Benefits	☐ Yes $_____	or	☐ Doesn't apply to me
Social Security Benefits	☐ Yes $_____	or	☐ Doesn't apply to me
Workman's Compensation	☐ Yes $_____	or	☐ Doesn't apply to me
Child Support	☐ Yes $_____	or	☐ Doesn't apply to me
Other (Alimony, etc.)	☐ Yes $_____	or	☐ Doesn't apply to me

Total Family Income: $_____

****Verification of income by a tax return or current pay stub is required for approval****

Client must sign this form stating the above information is true and accurate to the best of their knowledge. If their financial situation changes, they will notify Hoxworth Counseling Services immediately so a review and/or a revision of this application can be conducted.

(Temporary) Co-pay Fee Agreed Upon Per Session: $_____ for only _____ sessions.
The co-pay will return to our normal rates after the ten sessions have been used.
The normal co-pay rate is $_____.

_____ Date: _____

Client's Signature