Compass Mental Wellness Services, INC
413 High St., Seaford, DE 19973
302-394-6051
cmwsllc@cmwsllc.com
www.cmwsllc.com

"We will help you find your way"

COMPASS MENTAL WELLNESS SERVICES, INC.

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Please complete all applicable sections and return the application with income documentation.

Compass Mental Wellness Services offers discounted services to eligible patients based only on household income and family size. Insurance status does not determine eligibility. Applicants must provide reasonable documentation of income when available. Information provided on this application will be kept confidential and used only to determine eligibility for the Sliding Fee Discount Program.

1. PATIENT INFORMATION

Patient's full name: _____	**Date of birth:** _____
Parent/guardian name (if applicable): _____	**Relationship to patient:** _____
Street address: _____	**City/State/ZIP:** _____
Phone number: _____	**Email address:** _____

2. HOUSEHOLD INFORMATION

List every person who is part of the patient's household. Include the patient and anyone supported by or contributing to the household's income.

Household member name	Relationship	Date of birth	Gross monthly income

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Household member name	Relationship	Date of birth	Gross monthly income

Total number of people in household: _____ **Total gross household income: $_____** ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

3. HOUSEHOLD INCOME

Check all sources of gross household income that apply:

☐ Wages, salary, tips, or self-employment	☐ Social Security or disability benefits
☐ Unemployment or workers' compensation	☐ Pension or retirement income
☐ Child support or alimony received	☐ Veterans benefits
☐ Other income: _____	☐ No household income

If the household currently has no income, briefly explain how basic needs are being met:

_____
_____

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4. PROOF OF INCOME

Please provide the most recent documentation reasonably available for each household income source. Check the documents included:

☐ Recent pay stubs	☐ Most recent federal tax return
☐ Social Security/disability award letter	☐ Unemployment or workers' compensation statement
☐ Pension/retirement statement	☐ Employer income verification
☐ Self-employment records	☐ Other: _____

If standard documentation is not available, please speak with Compass administrative staff about other reasonable ways to verify income.

5. INSURANCE INFORMATION

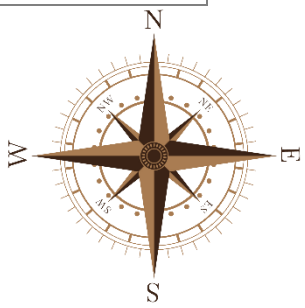
Do you currently have health insurance? ☐ Yes ☐ No	**Insurance company:** _____
Subscriber name: _____	**Member/Policy ID:** _____
Medicaid/Medicare, if applicable: _____	**Effective date:** _____

Note: Patients with insurance may still apply. The Sliding Fee Discount Program applies to eligible patient-responsibility amounts as permitted by law and payer requirements.

6. APPLICANT CERTIFICATION

I certify that the information provided on this application is true and complete to the best of my knowledge. I understand that Compass Mental Wellness Services may request additional information needed to determine eligibility. I agree to notify Compass if my household size or income changes. I understand that approval is time-limited and may require periodic renewal. I authorize Compass to verify the information provided when reasonably necessary.

Applicant/Responsible Party Signature: _____	**Date:** _____



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Printed Name: _____	**Relationship to Patient:** _____

FOR OFFICE USE ONLY

Date application received: _____	**Reviewed by:** _____
Household size verified: _____	**Annual household income verified: $** _____
Federal Poverty Guideline percentage: _____	**Approved discount category/tier:** _____
Effective date: _____	**Expiration/renewal date:** _____
☐ Approved ☐ Denied ☐ Pending additional information	**Date patient notified:** _____

Notes/Reason for denial or pending status:

_____

_____