Sliding Scale Worksheet
ALLOWABLE EXPENSES FOR ADJUSTMENT

DATE_____

CLIENT NAME_____

CLINICIAN NAME_____

Total Household Income $_____ Total # Supported By Income_____
(documentation of income required)

Please check the appropriate box indicating whether the amount recorded is a monthly or a yearly total

1. HOUSING:

Rent/Mortgage $_____ ☐ Monthly ☐ Yearly

Property Taxes $_____ ☐ Monthly ☐ Yearly
(If paid separately from mortgage payment)

2. GROCERIES:

Estimate Monthly Groceries $_____
(Excluding Food Stamps)

3. FAMILY SUPPORT:

Child Care $_____ ☐ Monthly ☐ Yearly

Child Support $_____ ☐ Monthly ☐ Yearly

Care of the Disabled/Elderly $_____ ☐ Monthly ☐ Yearly

Yearly School Tuition $_____

Camp Fees $_____ ☐ Monthly ☐ Yearly

4. HEALTHCARE COSTS

Health Insurance Premium $_____ ☐ Monthly ☐ Yearly

Yearly Deductible $_____

Additional Medical Expenses $_____ ☐ Monthly ☐ Yearly

Other_____ $_____ ☐ Monthly ☐ Yearly

By signing this you agree to pay the agreed upon amount retroactively to the first session.

Responsible Party Signature _____ Date:_____