Chesapeake Bay
Psychological Services LLC

Discount Application for Families

For families who are unable to pay our ordinary fees, CBPS can offer discounts based upon family size and income compared to poverty level. To determine if your family is eligible, please complete this form and return it with supporting documents by mail, fax (877-643-0126), or e-mail (admin@chesapeakebaypsychological.com). We will contact you after reviewing the completed application. Please note that for children of two households, this form must be completed for each household separately, and both households must meet eligibility criteria for a discount to be approved.

Client Name: _____ DOB: _____

Reason for Application: ❒ Inability to pay ❒ Other: _____

Household Members

List yourself (adult applicant) first, followed by the names of all household members (attach additional pages if necessary)	**Relationship to you**	**Date of Birth**	**Office Use Only**
	Self		

Annual Household Income

Source	**Self**	**Spouse/Partner**	**Other**	**Total**
Gross wages, salaries, tips, etc.				
Social security, pension, retirement, annuity, & veteran's benefits				
Child support, alimony, military family allotments				
Income from business, self employment, and dependents				
Unemployment, worker's compensation, disability				
Rent, interest, dividend, and other income				
Total Income				

Required Supporting Documents (please attach copies)

❒ **Documentation of Income:** Copies of most recent tax return OR three most recent pay stubs for each earner/job, OR if no income, letter from person/agency providing financial support

❒ **Application for Medicaid/MCHIP*—**ANY ONE of the following for this year: Copy of completed Medicaid application, proof of application, copy of Medicaid card, proof of approval, OR proof of denial

I certify that the information shown above is true and complete. Discounts apply to future services only.

Applicant Signature: _____

Printed Name: _____ Date: _____

Office Use Only: Approved for ❒ Nominal Fee of $_____ or ❒ Discount of: _____%

Effective date: _____ Expiration date: _____

Director Signature: _____ Date: _____

❒ Set up in TherapyAppointment for Nominal fee or Discount Initials: _____ Date: _____

*To apply for Medicaid/MCHIP, visit your local Department of Social Services office, apply online at www.marylandhealthconnection.gov, or call Maryland Health Connection at 1-855-642-8572.