**Application for Reduced Fee**

***Please email, fax, or attach a copy of a recent paycheck stub and/or other income information to this application.***

**Instructions:**

* To fax, please fax this Application and copy of a recent pay stub or copy of the first page of your tax return to Redeemer Counseling Services, confidential fax number: 212-252-0649.
* To submit by email, please attach a scanned copy of your paycheck or first page of tax return to the email: rcs@redeemer.com
* Reduced fees are based on current income. Therefore, fees are adjusted when income changes.
* Questions? Contact the Services Coordinator at 212-370-0475 x1365, or rcs@redeemer.com

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| **Personal Information** |  |
| Name:       | Date:       |
| [ ]  Full-time Work | [ ]  Part-time Work. Hours per week:       | Employer:       |
| [ ]  Full-time Student | [ ]  Part-time Student | [ ]  Not Employed | School:       |
| [ ]  New RCS Client | [ ] Current/Former client, counselor:       | [ ]  Other:       |
|  |
| **Spouse & Family Information** (please include other income earners in your family such as spouse/partner) |
| Other income earner name:       | Relationship to you:       |
| Occupation and status:       | Employer:       |
| Number of Dependents in family:       | Names and Ages:       |
| Total number of family/household members:       |
|   |
| **Family/Household Annual Income** |
| Please enter **Adjusted Gross Income** (pre-tax) of most recent tax return: $       Year       |
|  [ ]  Single Return [ ]  Joint Return |
| Has your employment changed since your last tax return? [ ]  Yes [ ]  No  |
| If yes, explain:       |
| Has your household/family income changed since your last tax return? [ ]  Yes [ ]  No  |
| If yes, explain:       |
|  |
| **Family/Household Current Monthly Income**  |
| Gross monthly wages or salaries (pre-tax) personal income: | $       |
| Gross monthly wages or salaries (pre-tax) from other family members: | $       |
| Income from other sources: Please explain:  | $       |
| **Gross Monthly Family/Household Total:**  | **$**       |
|  |
| **Additional Information** |
| Do you have Out-of-Network Insurance Benefits for Mental/Behavioral Health Services?       |
| Is there any additional information you would like us to consider?       |
| Signed       | Date       |