



The Grace Tree Foundation SLIDING SCALE WORKSHEET

We invite you to use this worksheet to determine your Sliding Scale Fee per service. After this primary application is submitted, you will be asked to resubmit your *Net Annual Household Income* every quarter to list updates. If you have an unpredictable or changing income, resubmitting as often as 1x month will be considered. All information contained herein will be kept confidential, accordance with HIPAA guidelines. Please submit two most recent pay stubs, and proof of financial payment responsibilities you have noted below. Please submit this application by scan, photo or by mail. You will receive an answer on this application within 2 weeks or sooner. Please submit to thegracetree@gmail.com.

Net Monthly Household Income

Income of all household adult earners after taxes, benefits and voluntary deductions are made from wages.

Your Occupation(s): _____

Your Net Monthly Earned Income (<i>Wage, Salaried, or Contracted*</i>) = 'A'	\$
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Your Other Monthly Income:

**Circle Y / N to indicate whether you receive the following income. If Y, enter amount received*

Unemployment Compensation	Y / N	\$
Public Assistance (<i>SSI, SNAP, TANF, Disability or other monetary support</i>)	Y / N	\$
Student Loan Income:	Y / N	\$
Child Support and/or Alimony:	Y / N	\$
Investment and/or Insurance Income	Y / N	\$
Family Support (<i>trust disbursements, gifts, tuition coverage, rent subsidy</i>)	Y / N	\$
Rental Property (<i>includes AirBnB</i>)	Y / N	\$
Pension and/or Veteran's Pension	Y / N	\$
Funds received from other adult earner/s in household	Y / N	\$
Other Income (<i>i.e., passive income streams</i>)	Y / N	\$
Sum of Other Monthly Income = 'B'		\$
Add together 'A' + 'B' to get Total Monthly Income = 'C'		\$

Monthly Household Expenses

We do not include basic costs that everyone pays such as rent, food, transportation, etc. but extra costs unique to different circumstances and communities.

Number of dependents _____ x \$335 monthly deduction (<i>based on Federal Dependent Exemptions</i>)	Y / N	\$
Child Care	Y / N	\$
Immigration-related Expenses	Y / N	\$
Remittances sent to home country	Y / N	\$
Other medical expenses not covered by insurance or extenuating circumstances. Please describe on page 2 to be considered.	Y / N	\$
Sum of Monthly Expenses = 'D'		\$

Your Total Net Monthly Household Income = 'E'

Subtract: Income 'C' _____ **– Expenses 'D'** _____ **= 'E'** \$ _____

Office Approval:		Yes	No	
Private Y12SR				\$ _____
Private GT Yoga Nidra™				\$ _____
Private GT TSY™				\$ _____
Private GT Meditation				\$ _____
Private EO Therapy				\$ _____
Community Classes				\$ _____
Community Regular Yoga				\$ _____
GT Somatic Trainer Fee™/Hour				\$ _____
Workshop 2 – 4 – 6 – 8:				\$ _____

Notes:

I attest the above information is correct and true, I have submitted copies of the original stubs, receipts, etc. requested and have included them in this application process.

Signature: _____ Date: _____

Please include any information you would like to be considered: