Exceptional Families Network
Membership and Sliding Fee Application

Parent/Caregiver Information		Today's Date:		
First Name:	Middle:	Last	Other Names:	
Home Address:		City:	State	Zip:
Mailing Address:		City:	State	Zip:
Home Phone: ( ) -	Cell Phone: ( ) -	Do you have insurance? Yes No (circle)		
Date of Birth: / /	Email Address:	Thank you for being part of Exceptional Families Network.		
Marital Status:	Single Married Divorced Separated Widowed			

→ **COMPLETE THE FOLLOWING SECTIONS ONLY IF APPLYING FOR SLIDING FEE**

Household Size

Name	Date of Birth	Social Security Number - Optional
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Household Income

Name	Amount	Frequency (circle one)	Employer
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
Total	$	Weekly Monthly Yearly	

NOTE:
In compliance with state and federal regulations, we are required to obtain personal information, in order to give you a discount on our services. Your information will be kept on file and in strict confidence.

Income must be verified annually. Please provide proof of family income, including but not limited to: income tax returns, W-2 form, paycheck stubs, copies of your social security checks, or other checks you may receive.

Only family size and annual income will be used to determine your eligibility and calculate your discount. Families will not be denied access due to inability to pay.

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement/Pension					
Food Stamps					
Child Support/Alimony					
Interest Income					
Other					
Total					**$**

Sliding Fee Scale:

A - 80% Discount

B - 60% Discount

C - 40% Discount

D - 20% Discount

E - 0% Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Exceptional Families Network if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Exceptional Families Network. I hereby acknowledge that I read the foregoing disclosure and understand it.

Name (Print):_____ Date:_____

Signature:_____

Membership Fees (please initial payment option):

_____ $25 per quarter ($2 quarterly processing fee will be applied)

_____ $100 per year (no processing fee with yearly membership paid in full)

NOTE: $10 registration fee (applicable if you have not been a member in the last 90 days)

Payment may be mailed to or dropped off at:
Exceptional Families Network
5605 100th Street SW, Suite A
Lakewood, WA 98499

Payments can also be made online at https://www.paypal.me/EFNetwork

Thank you for being a part of EFN!