Children's Services Council of Broward County
Our Focus is Our Children.

CSC Sliding Fee Scale Assessment Form

This form is offered to assist providers, as needed, in gathering information in order to assess program participants using the CSC Sliding Fee Scale, as required. **Participation in program services shall not be denied based on inability to pay; waivers may be granted on a case by case basis with documentation.**

Student's Name: _____ Student ID# _____

Name of School: _____ Student Grade: _____

Student's Ethnicity (*Please check one*) African American ☐ White (Non-Hispanic) ☐ Hispanic ☐

Guardian's Name: _____

Relationship to Student: _____ Language Spoken in Home: _____

Guardian's Marital Status (*Please check one*): Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____

Annual Gross Income: $_____ / Year Number of Family Members: _____

List any support documentation provided, i.e. Tax Return, Public Assistance, etc.: _____

With my signature below, I verify that the above information is true and accurate to the best of my knowledge. I will notify my counselor if my income status changes.

_____ _____
Parent/Guardian Signature **Date**

For Program Staff

Assessed Fee $_____/ Per Week

If Waiver, document reasons for waiver

_____
_____
_____

_____ _____
Authorized Staff Signature **Date**