Carmen B. Pingree
Autism Center of Learning™
A SPECIALTY SERVICE OF VALLEY

FORM B

Valley Behavioral Health
Carmen B. Pingree Autism Center of Learning
2016-2017 School Year
Application for Placement and Agreement to Pay with NO Financial Assistance (other than CSS) for **7th grade and above** or Adjusted Gross Income (AGI) over $115,000.00 and above

Please be sure to initial that all of the following are included *prior* to submitting the application:

1. _____ That this form is completed in its entirety
2. _____ To attach a **copy** of your most recently filed federal tax return
3. _____ To attach **copies** of payroll check stubs for the previous three months
4. _____ That signatures are completed in all areas

Student Name:	Student's Date of Birth:
Student's grade for 2015-2016:	Current Grade, School, and District:
1. Parent/Guardian Name:	2. Parent/Guardian Name:
Home Address:	Home Address:
City, Zip:	City, Zip:
Marital Status:	Marital Status:
Employer:	Employer:
Home Phone: Work Phone:	Home Phone: Work Phone:
How many dependents do you have?	How many dependents do you have?

* Has your child previously been approved by the Utah State Office of Education to receive Carson Smith Special Needs Scholarship Funds?	YES	NO
If NO, are you planning on applying for the Carson Smith Special Needs Scholarship Funds	YES	NO

Have you ever filed for bankruptcy? _____yes _____no Year: 19_____ 20____

I/we agree to pay a full tuition for the 2016-2017 school year, if my/our child is accepted into the VBH Carmen B. Pingree Center Autism Center of Learning. I/we additionally agree to provide the listed information above at the time of application. Furthermore, I/we authorize any required verification, including a credit bureau report.

I/we understand that if this information is determined to be false or deceptive, such a determination will result in denial of services and I/we will be liable for payment of charges for services rendered. I/we understand that some services provided may qualify for health insurance reimbursement and will be billed to my/our insurance plan. I/we further understand that the reimbursement received will be deducted from my obligation.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____

Complete and attach to Form A -OR- Form B

Specific MONTHLY Income Information		
	1 Parent/Guardian	2 Parent/Guardian
Wages (before deductions)		
Pensions		
Social Security Income		
Alimony/Child Support		
Dividends/Interest/Insurance		
Rental Income		
Estates and Trusts Income		
Public Assistance/Welfare		
Workers Compensation/ Disability		
Food Stamps		
Other		
Total:		

ASSETS			
Cash/Checking	$	Investments	$
Savings	$	Stocks/Bonds	$
Other	$		

Are there any extenuating circumstances that should be taken into account in determining potential financial assistance? You may attach an additional letter if you would like.

Application Agreement

I hereby state that the information given herein is true and complete. I authorize any required verification, including a credit bureau report. I understand that if this information is determined to be false or deceptive, such a determination will result in denial of uncompensated services and I will be liable of payment of charges for all services rendered.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date