



DreamCatchers Application for Reduced Fees

Please complete the following information to be considered for a reduced fee

Client Name: _____

Number of Adults in Household: _____

Number of Children up to age 18 in Household: _____

Do you currently receive SNAP or Medicaid? _____

Monthly Income Range:

_____ \$0 - \$1,500

_____ \$1,501 - \$2,500

_____ \$2,501 - \$3,500

_____ \$3,501 - \$4,500

_____ \$4,501 - \$5,500

_____ \$5,500 and up

I certify that the above stated income is true to the best of my knowledge. I agree that if my income changes by \$500 a month or more, I will recertify my income to be considered for reduced fees.

Signature: _____

Printed Name: _____