



Application for Fee Reduction

The Brain Wave Center, as a matter of policy, requests that anyone wishing to be considered for a reduction in the regular and customary fees, complete the following application.

1440 Main Street | Sarasota, Florida, 34236

Child's Name _____ Date of Birth _____

Parent's Name _____

Mailing Address _____

City _____ State _____ Postal Code _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Email Address _____

Employer(s) _____

Driver's License Number _____ Social Security Number _____

Must Include Income Verification: Attach copies of recent paychecks and income tax forms. If you feel you need special consideration, due to loss of job, medical expenses, etc., please explain your situation on the back of this form.

Names	Monthly Income				
	Gross Monthly Earnings	Monthly Welfare, Child Support, Alimony	Monthly Pensions, Retirement, Social Security	2 nd Job or Any Other Monthly Income	Total Monthly Income
List the names of everyone in your household					

Total Number of Household Members _____ Total Monthly Income _____

Parent Signature: Everything that I have stated on this application is correct to the best of my knowledge. I understand that you will retain this form whether or not financial assistance is given.

Parent Signature _____ Date _____



The Brain Wave Center™

Additional Information:

The Brain Wave Center’s mission is to contribute to our community by helping clients live happier, healthier, positive lives. We provide much needed access to high-quality, non-invasive brain function assessment and training. The Center is committed to excellence, leadership, and partnership with nationally and internationally recognized innovators in brain health technologies. Our vision is to Lead through Innovation - Serve with Compassion and with Understanding.

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