

Client ID \_\_\_\_\_



## Financial Assistance Application

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ SS#: \_\_\_\_\_

County of Residence: \_\_\_\_\_ (Eligible counties – Cass, Miami, Fulton and Pulaski)

Primary Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Client if different from Applicant: \_\_\_\_\_

List your household members, include yourself, spouse, children, and any person you claim as a dependent (you must verify dependents via tax return, copies must be attached to application)

**Please list spouse and dependents (under age 18)**

Name	DOB	SS#	Relationship
Client			
Spouse			
Dependent			
Dependent			

Do you or any household member have or have applied for Medicaid, Medicare, Disability, Social Security or any other Federally Funded Program? Yes / No If so, please list:

Name	Insurance Coverage Name	Policy Number

Name	How Paid? Weekly, Bi-Weekly, Twice a Month, or Yearly	Multiply by 52, 26,24,12 or 1	Total
<b>Total Gross Annual Income:</b>			

I (applicant) understand that that I must pay my discounted Fee Assistance amount at the time of service and pay any outstanding balances owed in order to continue on the Fee Assistance Program unless payments arrangements have been made and adhered to. *(please initial)* \_\_\_\_\_

I (applicant) hereby declare that anyone listed on this application listed as “no income received” does not receive any income from any source. *(please initial)* \_\_\_\_\_

I (applicant) understand that providing false information will result in termination of services and Four County may refer documents to an appropriate federal agency for further investigation. *(please initial)* \_\_\_\_\_

I (applicant) understand that I must renew this application every 6 months or if there is a change in the number of people or income status. *(please initial)* \_\_\_\_\_

I certify that the family size and income information shown above is correct. I understand that copies of tax returns, pay stubs, and other information verifying income is required before a discount will be approved. *(please initial)* \_\_\_\_\_

Signature of Patient/ Head of Household/Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Four County Counseling Center Agent: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach copies of the following documents:

Valid Photo ID

W-2

Paycheck stubs (last 30 days)

Income Tax Returns

Profit & Loss Statement from a self-employed business

Forms approving or denying unemployment or workers compensation

Written verification of wages from employer

Written verification from public welfare agencies or ay governmental agency that can attest to the patient’s income status for the past twelve (12) months

A Medicaid remittance voucher reflecting exhausted Medicaid benefits for the applicable Medicaid fiscal year

Medicaid verification of the Patient Share of Cost

Unless otherwise noted above, documentation should be for the most recent year/period available.

<b>Document Verification – FOR OFFICE USE ONLY</b>
Identification/Photo ID
Verification of address and county of residence
Income/Financial documents
Insurance Card where applicable
Presumptive Eligibility approval/denial letter
Gross Annual Income:
# of dependents:
Approved or Denied (circle one)
Percent to pay:
Date entered in Avatar:
Date letter sent to client:
Staff signature: