



Clients Name: _____ DOB: _____

Responsible Party (if different from client): _____

Address: _____

Day Phone: _____ Cell Phone: _____

Do you currently have health insurance? Y N

Insurance Name: _____ Policy #: _____

Number of people you will/would claim on taxes (include unborn child if applicable):

	AGE	Employed	FT or PT	Relationship to client
Client Name:		Y / N		Client
Responsible party: (If different than client)		Y / N		
Spouse/Domestic Partner:		Y / N		
Dependent:		Y / N		
Dependent:		Y / N		
Dependent:		Y / N		

Please enter **GROSS monthly** income for the **CLIENT/RESPONSIBLE PARTY/SPOUSE/DEPENDANTS**
PROOF OF INCOME IS REQUIRED

Source of Income:	<u>LAST MONTH</u>		<u>LAST 3 MONTHS</u>	
	<u>Client</u>	<u>All Other</u>	<u>Client</u>	<u>All Other</u>
None	<input type="checkbox"/>			
Wage/Salary	\$	\$	\$	\$
Public Assistance	\$	\$	\$	\$
Retirement/Pension/SSI	\$	\$	\$	\$
Disability/SSDI	\$	\$	\$	\$
Other: _____	\$	\$	\$	\$



Please make additional comments about your household’s financial circumstances that may affect your ability to pay for treatment:

- “I understand that by signing below I am attesting to the accuracy of the information in this form and authorize CCMH to verify any and all information on this application.
• I understand that falsifying any information on this form or in the supporting documentation I provide will result in re-evaluation of my request for a reduced fee, and possible disqualification.
• If it is determined that I have received services for a reduced fee using information I know to be false, I will be responsible for the full fees for these services.
• Should any of my financial or insurance information change, I understand that it is my responsibility to inform CCMH immediately so that my information can be updated and so that my eligibility can be re-evaluated.
• I understand that not all services offered at CCMH are eligible for the sliding scale discount.”

Client/Responsible Party’s Signature _____

Date: _____

For Office Use Only: Date Received: _____ Proof of Income Received: _____
Guarantor Account Number: _____ Guarantor Type: _____
Guarantor Account Number: _____ Guarantor Type: _____
Gross Income: _____ # in household: _____
Qualified For Reduced Fees: YES NO Rate: _____ Start Date: _____ End Date: _____
Bad Debt/Credible Balance: _____ PMT Plan: _____
Processing Specialist: _____ Date: _____
Supervisor Approval: _____
 FPL Updated
 Financial Assistance Tracker Updated
 Forms Scanned & Uploaded to Account
 Letter Mailed to Patient\Client