Application for Financial Assistance

The CENTER, a Samaritan Counseling Center

Date: _____ Chart Number:_____

Name: _____DOB: _____ SS#_____

Guardian/Parent Name (if applicant is a minor child): _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Age: _____ Gender: _____ Marital Status: _____ # People in Household: _____

Spouse's name: _____

Date of Last Insurance Coverage: _____

Annual Household Income (**all sources** for last 12 months): $_____

Client's Employer: _____ Spouse's Employer: _____

Served on active duty in the U.S. Armed Forces, military Reserves, or National Guard? ❑ Yes ❑ No

The information below is used for statistical information only and will not be used for any other reason.
If you have any questions of problems with this section please ask the office for assistance.

RACE (mark one)

Single Race:
____ White
____ Black or African American
____ Asian
____ American Indian & Alaskan Native
____ Native Hawaiian & Other Pacific Islander
____ Hispanic or Latino

Multi-Race
____ American Indian & Alaskan Native & White
____ Asian & White
____ Black or African American & White
____ American Indian & Alaskan Native & Black or African American
____ Balance / Other

Client/Guardian Signature: _____ Date: _____

----------Office Use Only----------

Payment
Client's Co-pay: $_____ Funding Source: (Circle source to bill) SCPF SS CDBG SWB

Census Tract Indicating Residency

Tract Location: _____ HUD Qualified Yes/No

Provider Assigned _____ Visit date_____ Provider Assigned _____ Visit date_____

Client's Income Verification is <u>REQUIRED</u>

Source of Verification: Paystubs/ Taxes/ W-2/ SWB Letter/ Other

Medicaid DCN#_____ Active/Inactive Medicaid Verification:_____

Approved by:_____ Rejected Reason:_____

(Continue on back)

Sliding Scale Applicant Attestation

The CENTER, a Samaritan Counseling Center

Please read and initial all statements below.

_____ Initial

I do not currently have insurance, Medicaid or Medicare that covers mental health services.

_____ Initial

I understand that if any information I provide is found to be false or invalid, all funding payments, therapist adjustments, and courtesy write offs will be refunded and I am responsible for payment in full.

_____ Initial

The use of a funding program is a contract entered in by The CENTER and myself to pay for services I receive. Proof of Income is required before fee for rendered services are paid by the funding sources. I understand that if Proof of Income is not provided or proved invalid or incomplete, I will be responsible for the full cost of services I receive. *Acceptable Proof of Income examples are: W-2 or Income Tax Return from previous year, two (2) current pay stubs, Social Welfare Board letter, Social Security Income/Disability income statement, etc. Bank Statements **ARE NOT** acceptable for Proof of Income per United Way and City Development Block Grant guidelines.*

_____ Initial

Client co payments must be made prior to every session unless prior arrangements have been made and approved. If three (3) co payments are missed The CENTER reserves the right to suspend service until the balance is paid in full.

_____ Initial

By signing below I attest that all information provided on the Application for Funding is correct and accurate.

_____ Initial

List all people residing in your place of residence:

Name	Age	Employment/School

You are potentially participating in a program funded by the City of St. Joseph, from Federal funds provided by the U.S. Department of Housing and Urban Development (HUD). The information in this form will be used only for the purpose of compiling reports required by HUD for activities funded by the Community Development Block Grant, Emergency Shelter Grant, HOME Investment Partnership programs, Social Welfare Board, Silent Samaritans, and Samaritan Caring Partners Fund.

Penalty for false or fraudulent statement: (U.S.C. Title 18, Sec. 1001) provides, "Whoever, in any matter within the jurisdiction of any department or agency of United States knowingly and willfully falsifies... or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000, or imprisoned not more than 5 years, or both".

I, the undersigned, have read and understand the above statements and hereby certify all information provided on this form is true on date of registration.

Client/Guardian Signature: _____

Date: _____ ***Initials:*** _____ ***SS Number:*** _____