

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE'S NAME: _____
 ADDRESS _____
 PHONE NUMBER (_____) _____

CONTACT PERSON & PHONE NUMBER: _____
 If Self-Employed, Name of Business _____

SPOUSE EMPLOYER _____ POSITION _____
 CONTACT PERSON & PHONE NUMBER _____
 If Self-Employed, Name of Business _____

CURRENT MONTHLY INCOME

	Patient	Other/Family
(Add) Gross Pay (before deductions)	_____	_____
(Add) Income from Operating Business (if Self-Employed)	_____	_____
(Add) Other Income: Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Other (specify):	_____	_____
Alimony or Support Payments Received	_____	_____
(Subtract) Alimony, Support Payments Paid	_____	_____
(Equals) Current Monthly Income	_____	_____
Total Current Monthly Income (add Patient + Spouse) Income from above	_____	_____

FAMILY SIZE (Add Patient, Parents (for minor patients), Spouse, and Children from Above)
 Total Family Members _____

	YES	NO
Do you have health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other insurance that might apply (such as auto policy)?	<input type="checkbox"/>	<input type="checkbox"/>
Were your injuries caused by a third party (a car accident, a slip, or fall)?	<input type="checkbox"/>	<input type="checkbox"/>

By signing this form, I agree to allow Aliso Ridge Behavioral Health (ARBH) to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. ARBH will consider other forms of proof of income if submitted.

 SIGNATURE DATE Signature of Spouse DATE



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