Children's
Recovery Center
of Northern California

FINANCIAL ASSISTANCE APPLICATION

Date of Application _____

PATIENT INFORMATION	PLEASE PRINT ALL INFORMATION		
Last Name	First Name	Middle Initial	Medical Records Number

If the patient is a minor, please list parents(s) guardian(s) as applicant and co-applicant

APPLICANT (GUARANTOR) INFORMATION	RELATIONSHIP TO PATIENT ☐ Self ☐ Parent ☐ Guardian			
	MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Separated			
Last Name	**First Name**	**Middle Initial**	**Social Security Number**	**US Citizen ☐ YES ☐ NO**
			- -	

Date of Birth	**No. of Dependents (other than self & co-applicant)**	**Ages of Dependents**	Home Phone Number
			( ) -

Street Address (Do not list PO Box)	City	State	County	Zip

Current Employer	Street Address, City	State	Position	Years

*If you are not working, how long unemployed?

CHILDREN'S RECOVERY CENTER FINANCIAL ASSISTANCE APPLICATION

FINANCIAL ASSISTANCE QUESTIONS:

Is the patient applying for assistance with bill for past services at Children's Recovery Center? If yes, please indicate the last service Date:_____	_____ Yes _____ No
Is the patient applying for assistance with bills for current and/or future services at Children's Recovery Center? If yes, please indicate/describe the types of services anticipated:_____ _____ _____ _____	_____ Yes _____ No
Is the patient applying for a discount off their bills for services from Children's Recovery Center?	____ Yes ____ No
Is the patient applying for 100% assistance from Children's Recovery Center for services provided at Children's Recovery Center?	___ _ Yes ____ No
Does the patient have health insurance? If yes please provide the following information: Health Insurance Name: _____ Subscribers Name: _____ Members/Patient Identification Number _____Group #_____ Group/Employer Name: _____ Effective Date _____ Health Insurance Phone Number ( )_____	____ Yes ____ No
Is the patient eligible for state medical assistance program? If yes, please provide the following information: Name of Program: _____ County: _____ Patient ID Number: _____	____ Yes ____ No

INCOME INFORMATION

Monthly Income Source	Applicant	Co-Applicant	Combined Monthly Income
Employment	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other (s) Use these spaces	$	$	$

CHILDREN'S RECOVERY CENTER FINANCIAL ASSISTANCE APPLICATION

ESTIMATED MONTHLY LIVING EXPENSES

Monthly Expenses	Monthly Payments	Monthly Expenses	Monthly Payment
House/Mortgage Payment	$	Current Outstanding Bills for Medical, Dental/Prescriptions	$
Property Taxes (if not included in mortgage payment)	$	Total Monthly Auto Payment	$
Home Owner's Insurance (if not included in mortgage payment)	$	Automobile Insurance	$
Utilities (Electricity, Gas, Water, Garbage, Recycling, etc.)	$	Automobile Gasoline	$
Food	$	Liens/Wage Garnishments	$
Telephone (home line/or cell	$	List other monthly payments	$
Child Support	$		$
Spousal Support/Alimony	$		$
Child Care	$		$
Credit Cards	$		$
Health Insurance Premiums	$		$
		Total Monthly Payments	$

==========

I certify that all information is valid and complete and hereby authorize Children's Recovery Center to request a credit check report and/or verify any of the above information as deemed necessary.

Applicant _____ Date _____ Co-Applicant _____ Date _____

Please return completed application to: Children's Recovery Center-Administration
3777 S. Bascom Ave
Campbell, CA. 95008