## APPLICATION FOR FINANCIAL ASSISTANCE (FREE and DISCOUNT CARE)

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 |
|---|---|---|---|
| | 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? | ☐ | ☐ |
| Do you have other insurance that might apply (such as auto policy)? | ☐ | ☐ |
| Were your injuries caused by a third party (a car accident, a slip, or fall)? | ☐ | ☐ |

When applying only for discount payment program eligibility, Aliso Ridge Behavioral Health may only request recent paystubs or income tax returns for documentation of income. Other forms of documentation of income may be requested, but may not require them. Patients applying only for discount payment program eligibility may receive less financial assistance than what may be available under our Free Care program.

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

**Attachment A - APPLICATION FOR FINANCIAL ASSISTANCE**