MIND SPRINGS *health* Prevention. Care. Recovery. WEST SPRINGS *hospital* Psychiatric Care & Recovery

Financial Assistance Application (FAA)

Instruction: Complete entire application, sign, and date.

Client Demographics:

Client Name	Date of Birth	SSN # (Optional)
Address	City, State, Zip	Phone Number

Please circle all responses

Are you a U.S. citizen? (Optional) No Yes Are you a documented immigrant? (Optional) No Yes
Are you claimed as a dependent on anyone's taxes? No Yes
Who claims you as a dependent? _____

*Provide copy of insurance card(s)
Do you have health insurance? No Yes Insurance Name & ID: _____
Do you have Medicare? No Yes Medicare ID #: _____
Do you have Medicaid? No Yes Medicaid ID #: _____
Have you applied for Medicaid? No Yes Date applied for Medicaid: _____

Are you currently incarcerated? No Yes How long have you been incarcerated?: _____

Marital Status (Optional): Single/Never Married Married Legally Separated Divorced Widowed

Household Income: Include any person that receives 50% of financial support from household.

	List Household members	**Relationship**	**Date of Birth**	**Employer/Source**	**Gross Income**
1		Self			
2		Other			
3		Other			
4		Other			
5		Other			
Annual Household Gross Income					**$**

____ I am currently unemployed and do not qualify for unemployment benefits.
____ I have no source of income at this time. **
____ I am homeless and/or lack permanent nighttime residence. **
**If checked, complete the Homeless/Zero Income Attestation

Should you have any questions, a financial counselor is available to assist you.
Monday – Friday 8:00am to 4:00pm toll free 1(888)320-5218

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Must include applicable items from this proof of income verification list (Exhibit B)

Income Type	Supporting Documentation	MSH Use Only
Wages/Tips/Salary	Paystubs	
Unemployment Compensation	Award letter or statement	
Self-Employment Income	Prior year income tax return or YTD profit/loss statement	
Worker's Compensation	Award or Determination of Benefits letter	
SSI or SSDI	Benefit letter, Statement of benefits received, notice of award	
Alimony	Court Decree	
Rental Income	Copy of Lease	
Trust Fund	Letter from Trustee	

Inpatient Only

____ I approve WSH to contact my employer to obtain my income verification, complete a ROI form.
____ I do not approve WSH to contact my employer for income verification.

Additional Information:

_____
_____
_____
_____

I hereby certify that the information listed herein is correct to the best of my knowledge and give Mind Springs Health/West Springs Hospital permission to verify any information listed. I understand that if I do not provide proof of income, the application is incomplete, and I will be expected to pay the balance that has been deemed my responsibility, in full.

Client/Patient or authorized representative signature: _____

Print Name: _____ Date: _____

MSH/WSH Use Only
Client ID: _____

Staff: _____ Date: _____

POI Verified: Yes No FPL _____%
Eligibility: Approved Denied
Type: OBH Internal

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Homeless/Zero Income Attestation

Instructions: Complete form if you have indicated no source of income, are homeless, and/or lack permanent nighttime residence on the Financial Assistance Application (FAA).

I, _____, do hereby certify that I do not receive income from any source.

I understand sources of income include, but are not limited to the following:

- Money, wages, salaries, and tips
- Regular payments from Social Security, retirement, unemployment benefits, workers' compensation, veterans' compensation, public assistance, and training stipends
- Alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions, and regular insurance or annuity payments
- College or University scholarship, grants, fellowships, and assistantships
- Dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings

Please explain below how you (or your family) have paid these three living expenses when your household has no income:

Food _____

Utilities _____

Housing _____

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact subjects me to disqualification from financial assistance.

Client/Patient or authorized representative signature: _____

Print Name: _____ Date: _____

Should you have any questions, a financial counselor is available to assist you.
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