WEST CENTRAL BEHAVIORAL HEALTH

FINANCIAL ASSISTANCE PROGRAM FOR THE UNINSURED CLIENT

Purpose

As a community based, not-for-profit organization, West Central Behavioral Health is committed to serving its community. The Agency's financial assistance program seeks to objectively evaluate the circumstances of individual clients and responsible parties and to offer community service in the form of financial assistance where it is needed and appropriate with respect to sound business practices.

Our mission is to promote, preserve and strengthen the mental health and quality of life in our community. We are committed to delivering behavioral health services to people in need and make every effort to identify clients in need of financial assistance, prior to and during the delivery of services.

This program is designed to provide our clients in need of medical care with financial assistance in regards to the services they receive at West Central Behavioral Health if they do not have coverage for their medical expenses. Clients who choose not to bill their insurance for services are not eligible for financial assistance. Clients experiencing a financial burden associated with their health care costs but do not qualify for a discount under this program may contact the Client Financial Services Representative at the site where they receive services to discuss payment plan options.

The following steps outline the process for applying for financial assistance with the Agency.

Procedure

At the time of registration as a new client and anytime during the delivery of services as the situation warrants, clients may complete a financial assistance application. This application must be accompanied by one of the following supporting documents as proof of income for all dependent household members:

- Complete 1040 tax return accompanied by the applicable W-2 forms for the previous calendar year.
- Unemployment compensation determination letter.
- Four current and consecutive pay stubs from all employers
- Copy of your social security check, pension check or yearly determination letter if you are retired.
- Worker's compensation determination letter or a copy of your worker's compensation check.

Financial assistance applications may be obtained at any of the Agency's sites from a Client Financial Services Representative, Intake Secretary or Reception staff.

The client is responsible for paying all charges incurred prior to the approval of a financial assistance application. Applications shall be reviewed and a determination communicated to the client within 5 business days of receipt of the completed application and attachments.

A financial assistance application must be updated by the client as circumstances change but, at a minimum on an annual basis.

9/7/2010

West Central Behavioral Health

Affiliate of the Department of Psychiatry, Dartmouth Medical School

FINANCIAL ASSISTANCE APPLICATION

TO BE COMPLETED BY THE CLIENT

Client Name _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Marital Status ___ Married ___ Separated ___ Single

Number of Dependents _____
(Please list names and relationship)

_____
_____
_____
_____
_____

Has the client receiving services applied for Medicaid? ___ yes ___ no ***(please attach proof of application)***
If an application has been filed, please state the date of the application, name of the party filing, and the status of the application:

_____
_____
_____

Is anyone in your household covered by health insurance benefits? ___ yes ___ no

If yes, please state name of covered individual(s)

_____

By signing below I certify that all information submitted with this application is accurate. I agree to notify West Central Behavioral Health if my financial position changes so, that it may have an impact upon my eligibility for financial assistance with the Agency over the next twelve months.

If I am a New Hampshire resident and requesting reduced fee substance abuse services from West Central Behavioral Health, I agree to allow West Central Behavioral Health to share specific demographic, clinical, health and financial information with the State of New Hampshire, Bureau of Drug and Alcohol Services in order to secure low-fee clinical care.

_____ _____

Applicant's Signature Date

_____

FOR OFFICE USE ONLY

Client Number _____

Income Documents reviewed:

___ Income tax return/W-2
___ Unemployment compensation determination letter
___ Pay Stubs Dates to _____ from _____
___ Proof of Medicaid application
___ Other Describe: _____
_____

Comments: _____
_____
_____

Financial Assistance Determination:
___ Approved
___ Denied Reason: _____

_____ _____

Signature Date