West Central Behavioral Health

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 and/or the New Hampshire Insurance Marketplace?
____ 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)

Please provide proof of household income with completed financial application

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.

_____ _____

Applicant's Signature Date

_____

_____

FOR OFFICE USE ONLY

Client Number _____

Income Documents reviewed:

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

Comments:

Financial Assistance Determination:
___ Approved
____Approved – Spend down discount
____Approved – Non covered services
___ Denied Reason: _____

_____ _____

Signature Date