

**FINANCIAL ASSISTANCE APPLICATION (FAP)  PATIENT ASSISTANCE FUND APPLICATION (PAF)**

I understand that the information submitted concerning my annual income, family size and assets, is subject to verification by Pine Rest Christian Mental Health Services. I also understand that if the information submitted is determined to be false, this will result in a denial of this application and the account balance due will remain my responsibility.

SECTION ONE: PATIENT INFORMATION (Please print)							
Account Number		Date(s) of Service			Social Security Number		
Patient Name (Last, First, Middle Initial)				Date of Birth			
Address			City		State		Zip
Home Phone ( )		Cell Phone ( )		Other Phone ( )		County	
Marital Status Single Married Divorced Other _____		Are you a legal resident of the United States? Yes No			Did you have health insurance or any other coverage at the time of your service? Yes No		
Do you file a Federal Tax Return? Yes No If No, why? _____		Who is the primary filer? Self Spouse Other: _____			Does anyone in the home receive public assistance? Cash Food Other: _____		
SECTION TWO: GUARANTOR/RESPONSIBLE PARTY INFORMATION							
Guarantor/Responsible Party: Name (Last, First, Middle Initial)				Date of Birth		Social Security Number	
Address			City		State		Zip
Cell Phone ( )		Other Phone ( )		County		Relationship to Patient	
SECTION THREE: HOUSEHOLD INFORMATION (List all people who live in your household)							
Name of Household Member	Date of Birth	Relationship to Patient	Is this person listed on your Federal Tax Return?	Name of Household Member	Date of Birth	Relationship to Patient	Is this person listed on your Federal Tax Return?
1.			Yes No	4.			Yes No
2.			Yes No	5.			Yes No
3.			Yes No	6.			Yes No
Any additional household members can be submitted on additional paper.							
SECTION FOUR: EXPENSES (List monthly expenses for all household members)							

House Payment	Car Payment	Heat	Cell Phone
Property Taxes (Year)	Car Insurance	Electric	Groceries
Rent/Lot Rent	Fuel (vehicle)	Phone	Tuition
House/Rental Insurance	Childcare/Child Support	Water/Sewer/Trash Removal	Other: _
Health Insurance/Expenses	Life Insurance	Cable/Dish/Internet	Other: _

**SECTION FIVE: INCOME (List income for all household members)**

Monthly Income Source	What household member receives this income?	Current Monthly Gross Income Amount	Monthly Income Source	What household member receives this income?	Current Monthly Gross Income Amount
Wages			Wages		
Self-Employment			Self-Employment		
Child Support/Alimony			Child Support/Alimony		
Social Security			Social Security		
Investments			Investments		
Pension/Dividends			Pension/Dividends		
Tips/Commission			Tips/Commission		
Interest			Interest		
Rental Income			Rental Income		
Tribal Income			Tribal Income		
Unemployment			Unemployment		
Worker's Compensation			Worker's Compensation		
Other: _____			Other: _____		

**SECTION SIX: HOUSEHOLD ASSETS (List assets for all household members)**

Asset Source	What household member owns this asset?	Current Asset Value	Asset Source	What household member owns this asset?	Current Asset Value
Checking Account			Property (Home) Value		
Checking Account #2			Property #2 Value		
Savings Account			Vehicle (primary) Value		
Savings Account #2			Vehicle #2 Value		
CD's/ Money Market			Motorcycle/ATV/Boat/Trailer		
401k/403B/IRA/Retirement			Life Insurance (surrender value)		

Stocks/Bonds/Annuity			Other: _____		
HSA/ FSA			Other: _____		
<b>SECTION SEVEN: COVERAGE/REQUESTED AMOUNT (PAF request only)</b>					
Patient Reason for Request:				Patient Requested Amount: \$	

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 If you have any questions, please call: \_\_\_\_\_ at ( ) \_\_\_\_\_

**To be completed by Pine Rest staff for PAF request:**

Clinical Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Director of Division Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>To Be completed by Pine Rest</b>	<b>Patient Responsibility: \$</b>		<b>Deductible \$:</b>	<b>Meets Requirements:</b>	
	<b>Approved:</b> Yes No		<b>Reason if applicable:</b>		<b>Approved: \$</b>