Barber Behavioral Health Institute

Charity Care Application

Patient Name: _____

Birthdate: _____/_____/_____ SSN: _____-_____-_____

Home Address: _____ City_____ State____ Zip Code_____

Phones: Day (_____) _____ Other: (_____) _____

Employer Name: _____ Phone: (_____) _____

Marital Status: Single __ Married __ Divorced __ Separated __ Widowed __

Spouse/Guarantor Name: _____ Relationship to patient: _____

Guarantor Address: _____ City_____ State____ Zip Code_____

Guarantor Phones: Day (_____) _____ Other: (_____) _____

Household Members: List all in the patient's household who are claimed on IRS form 1040

Name	Relationship to Patient	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Home: Please check, patient/guarantor: Owns Home___ Rents Home____ No Home____
If home is owned, please list:
Assessed Value: $_____ Amount still owed on mortgage: $_____
If patient/guarantor has an interest in other real estate, please list:
Address: _____ City_____ State___ Zip Code_____
Names of co-owners:_____
Assesses Value: $_____ Amount still owed on mortgage: $_____

Motor Vehicles: Please list make, model and year of each motor vehicle:
_____Owned___ Lease_____
_____Owned___ Lease_____

Bank Accounts: Please list the following information and attach 2 months of statements for each bank account such as Checking, Savings, Certificates (CDs), Money Market, etc.

Account Type	Bank or Financial Institution Name	Account Number	Current Balance
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

Investments: Please list the following information and attach 2 months of statements for each investment, such as stocks, bonds, mutual funds, etc.

Investment Type	Bank or Financial Institution Name	Current Value
_____	_____	$_____
_____	_____	$_____

Total Household Monthly Income: Include the total for the household (patient and all others) for all income, including wages, Social Security, pension or other retirement income, alimony, child/spousal support, rent/royalty/self-employment income, veterans/disability payments, unemployment compensation, worker compensation and investment (interest, dividend) income.

Proof of income must be provided as listed on the instruction page.

	Patient:	**Spouse:**
Total Household Wage:	$_____per month	$_____per month
Total Social Security:	$_____per month	$_____per month
Total Pension, other Retirement:	$_____per month	$_____per month
Total Worker Comp:	$_____per month	$_____per month
Total Unemployment Income:	$_____per month	$_____per month
Total Alimony/Child Support:	$_____per month	$_____per month
Total Rent/Royalty Income:	$_____per month	$_____per month
Total Dividends and Interest:	$_____per month	$_____per month
Total other income:	$_____per month	$_____per month
Total Household Income:	$_____For Month	$_____For Month

Other Information:

Have you applied for Medical Assistance? No____ Yes_____ (If yes, please provide copies of your determination letter)

Are you a citizen of the United States? No____ Yes____

Did you have health insurance at the time of your treatment? No ____ Yes____

Authorization and Verification

I, _____, attest that the information provided in this form is true and correct to the best of my knowledge. I understand that this form and the proofs of my income will not be returned. I authorize Barber Behavioral Health Institute to verify the information to determine my eligibility for charity care. I understand that if any information is found to be false, I may be denied charity care, and will be solely responsible to pay my bill in full.

Signature: _____ Date: _____
(Patient or Representative/Guarantor)

Relationship to Patient: _____