FINANCIAL ASSISTANCE APPLICATION

ELIGIBILITY FOR THIS PROGRAM IS BASED ON FINANCIAL NEED

Why does Burke Recovery need to know your household income?
Some of our program budget comes from grant money. For most of these grants, income information from all of our patients is necessary to prove financial need in the communities we serve. The grant monies allow us to provide a higher level of quality and more services than we could without them. In order to get and keep these grants, we need to provide income information to prove that we are serving the people the grant money has been set aside for.

ALL INFORMATION IS CONFIDENTIAL

Definition of Household:
All members of a household who are related and pooling financial resources are counted as one family if the arrangements are considered permanent and support greater than room and board is provided.
Unrelated members of a household who are supporting one another financially are considered one family.

Definition of Underinsured:
If a client has insurance that does not cover behavioral health services, the client is considered "underinsured."

Definition of Income:
Income is defined as total cash before taxes from all sources, which can include:

- Wages and salaries;
- Receipts from self-employment after deductions for normal operating expenses;
- Regular payments through public assistance, social security, longevity, unemployment, strike benefits, military allotments, disability, rental income, regular support from an absent family member or someone not living in the household (includes child support), government or private pensions, and regular insurance or annuity payments;
- Savings accounts (average balance of past 6 month's activity, divided by 6 months' equal monthly portion of income).

How do I qualify?
To become qualified, all applicants for discounted services must be *uninsured or underinsured, and have an income below 250% FPL.* All qualified applicants are asked to provide proof of household income and family size to qualify for discounted fees. The application needs to be completed and verified before your initial appointment with a clinician. Intake appointments are completed at no charge and therefore do not require the completion of an application.

Required Documents for Review
Each client requesting a discounted charge will need to provide, in addition to the following application, proof of the information listed. This proof includes the following:

- Proof of all monthly earnings (can be pay stubs, former year tax returns, or bank deposit records/bank statements) - for past 3 months and for every household earner
- Proof of other benefits (child support, alimony, VA benefits, disability, etc.)
- Proof of residency

Disclaimer:
All applications will be reviewed objectively and the only determination for application approval will be based on financial ability to pay. Approval will not be based on age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Financial Assistance Eligibility Worksheet

Name: _____ Date of Birth: _____ SSN:_____
Last First MI

You must provide proof of income to qualify for the discount schedule. This information must be updated at least annually, and any time your household income size and/or medical insurance status changes. You will be responsible for the full amount of the visit and the discount will not be applied to your account until you give us the required proof income. If proof of income is given to us within 30 days of the visit, and if you are eligible, the discount will be applied retroactively and all the following visits will be discounted. Proof of income includes prior year completed income tax forms, pay stubs from the last three months, unemployment or other benefits income receipts, and/or letters of income verification from two other individuals.

List your name and the names of ALL individuals who live with you.

Name	Relationship	Age	Gender	Date of Birth	Annual Income	Employer
	SELF					

If you need more space, please continue on the back of this form.

Are you currently employed? ☐ Yes ☐ No Do you work seasonally only? ☐ Yes ☐ No
How much money do you and all who live in your household bring in per: Month $_____ Year $_____
If you are not working, how are you meeting your monthly expenses? ☐ Savings ☐ Borrowing ☐Other_____
_____

Amount in Savings $_____ Bank Name _____
Amount in Checking $_____ Bank Name _____
Do you have health insurance? ☐ Yes ☐ No If yes, what is the deductible amount? $_____
Do you have Medicaid? ☐ Yes ☐ No Did you apply? ☐Yes ☐No Where you denied? ☐ Yes ☐ No
Do you have Medicare? ☐ Yes ☐ No Are you eligible to apply? ☐ Yes ☐ No

List your total household income (ALL that you and those living in your household are receiving):

	Yes	No	Amount per month/year
Salary of Wages	☐	☐	_____
Unemployment	☐	☐	_____
Social Security	☐	☐	_____
Pension/Retirement	☐	☐	_____
Rental Income/Dividends	☐	☐	_____
Interest	☐	☐	_____
Spousal Support	☐	☐	_____
Child Support	☐	☐	_____
Foster Care	☐	☐	_____
Public Assistance (ATAP)	☐	☐	_____
Permanent Fund	☐	☐	_____
Longevity Bonus	☐	☐	_____
Self-Employed (net amt)	☐	☐	_____
Worker's Comp Benefits	☐	☐	_____
Disability Benefits	☐	☐	_____
Other	☐	☐	_____

Total Monthly/Annual Household Income:_____

PLEASE READ AND SIGN ON FOLLOWING PAGE

I certify that the statements made to Burke Council on Alcoholism and Chemical Dependency, DBA Burke Recovery, regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and/or subject to legal action for knowingly providing false information. I agree to notify Burke Recovery of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential except for the purposes noted above and not be released without my written permission. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the Executive Director.

Signature: _____ Date: _____

We are glad you are seeking services at Burke Recovery and will do our best to ensure you receive the services and/or referrals you need to best meet the needs of your recovery.

OFFICE USE ONLY:

Total Annual Income: _____ # of Family Members: _____

Verified by:_____ Date: _____

Verified with: ☐ Pay Stubs ☐ Tax Forms ☐ Bank Statements ☐ Other _____

Proof returned (Date): _____

Discount Effective Date: _____

Qualified? ☐ **Yes** ☐ **No** Payment Category: ☐ IPRS ☐ Discounted ☐ Self-Pay

Requalify Date: _____