

**APPLICATION FOR FINANCIAL ASSISTANCE (FREE and DISCOUNT CARE)**

PATIENT NAME \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 PHONE NUMBER (\_\_\_\_\_) \_\_\_\_\_

CONTACT PERSON & PHONE NUMBER: \_\_\_\_\_  
 If Self-Employed, Name of Business \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_  
 CONTACT PERSON & PHONE NUMBER \_\_\_\_\_  
 If Self-Employed, Name of Business \_\_\_\_\_

**CURRENT MONTHLY INCOME**

		Patient	Other/Family
	Gross Pay (before deductions)	_____	_____
<i>(Add)</i>	Income from Operating Business (if Self-Employed)	_____	_____
<i>(Add)</i>	Other Income: Interest and Dividends	_____	_____
	From Real Estate or Personal Property	_____	_____
	Social Security Other	_____	_____
	(specify):	_____	_____
	Alimony or Support Payments Received	_____	_____
<i>(Subtract)</i>	Alimony, Support Payments Paid	_____	_____
<i>(Equals)</i>	Current Monthly Income	_____	_____
	Total Current Monthly Income (add Patient + Spouse)	_____	_____
	Income from above	_____	_____

**FAMILY SIZE** (Add Patient, Parents (for minor patients), Spouse, and Children from Above)

Total Family Members \_\_\_\_\_

	YES	NO
Do you have health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other insurance that might apply (such as auto policy)?	<input type="checkbox"/>	<input type="checkbox"/>
Were your injuries caused by a third party (a car accident, a slip, or fall)?	<input type="checkbox"/>	<input type="checkbox"/>

When applying only for discount payment program eligibility, Aliso Ridge Behavioral Health may only request recent paystubs or income tax returns for documentation of income. Other forms of documentation of income may be requested, but may not require them. Patients applying only for discount payment program eligibility may receive less financial assistance than what may be available under our Free Care program.

By signing this form, I agree to allow Aliso Ridge Behavioral Health (ARBH) to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. ARBH will consider other forms of proof of income if submitted.

\_\_\_\_\_  
 SIGNATURE                                      DATE                                      Signature of Spouse                                      DATE

