WILLOW OAK COMMUNITY BEHAVIORAL HEALTH SERVICES

APPLICATION FOR FINANCIAL ASSISTANCE FOR
BEHAVIORAL HEALTH SERVICES & CONNECTS AUTHORIZATIONS

TODAY'S DATE:_____

If you need help in completing this form or if you have questions about this form a staff member will be happy to assist you.

Payment for services is expected. If you do not have health insurance, you can complete this form in order to determine if you qualify for state financial assistance in paying for your services. In order to qualify for this assistance, you will also need to provide proof of income such as copies of recent pay stubs or your most recent tax return.

In order for us to bill your health insurance company, Medicaid or Medicare you will need to provide proof of your insurance, including the group number and policy number. You will be responsible for any co-payments or deductibles required by your insurance policy.

This application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. Failure to provide accurate information may result in you being charged the full charge or in the denial of services.

Name: _____ CID # _____

Address: _____

City, State & Zip: _____

Phone #: Home _____ Work _____ Cell _____

Social Security #: _____ - _____ - _____

METHOD OF PAYMENT:

1. Self-Pay ☐ 2. Medicaid ☐ #: _____ 3. Medicare ☐ #: _____

4. Insurance ☐ Company: _____

Group #: _____ Policy #: _____

Is pre-certification required? ☐ Yes ☐ No Verification of coverage complete? ☐ Yes ☐ No

5. Co-Insurance ☐ Company: _____

Group #: _____ Policy #: _____

Is pre-certification required? ☐ Yes ☐ No Verification of coverage complete? ☐ Yes ☐ No

6. Currently in Jail? ☐ Yes ☐ No County/City: _____

7. Employed ☐ Employer: _____ Unemployed ☐ Retired ☐

TANF ☐ SSI ☐ Social Security ☐

8. If unemployed, date of last employment: _____ / _____ / _____ Previous Place of Employment: _____

Did you have insurance coverage? ☐ Yes ☐ No If Yes, Name of the

Insurance Company: _____

Group Number: _____ Policy Number: _____

INCOME: (Combined Family/Guardian)

1. Are you claimed as a dependent on someone's Federal or State income Tax? ☐ Yes ☐ No
If yes, what is the relationship? Parent ☐ Other Relative ☐ Legal Guardian ☐ Other ☐
If yes to above, the following questions apply to the household income. If the answer to the above is no, then report only income of those individuals reported on your last tax return.

	Initial	**Update**	**Update**	**Update**
Date of Application Reviews	Date:	Date:	Date:	Date:
	Amount	**Amount**	**Amount**	**Amount**
Monthly Income from Wages				
Individual Gross Wages	$	$	$	$
Spouse Gross Wages	$	$	$	$
(18 years of age or younger or as a dependent on income tax) Legal Guardian 1 Gross Wages	$	$	$	$
Legal Guardian 2 Gross Wages	$	$	$	$
Monthly Income from Other Sources				
SSI	$	$	$	$
TANF	$	$	$	$
V.A.	$	$	$	$
Child Support	$	$	$	$
Alimony	$	$	$	$
Social Security	$	$	$	$

Retirement/Pension payments	$	$	$	$
Trust Fund payments	$	$	$	$
Other regularly scheduled payments	$	$	$	$
Total Monthly Income	$	$	$	$

ALLOWABLE MONTHLY DEDUCTIONS
It may not be necessary to fill out the following section.
You are welcome to discuss this with a staff member at this point.

Child Support	$	$	$	$
Alimony	$	$	$	$
Monthly Child Care Payments necessary to work	$	$	$	$
Monthly non-court ordered Child Support Payments	$	$	$	$
Monthly Medical Expenses in excess of 5% of gross income	$	$	$	$
TOTAL ALLOWABLE DEDUCTIONS	**$**	**$**	**$**	**$**
Adjusted Monthly Income (Total Monthly Income Minus Total Allowable Deductions)	$	$	$	$
Number of Family Members (Including Self)				

Based on this information and the attached fee scale, the determined charge(s) for my services are listed below:

Service	Individual Fee Amount Per Established Period- U6 in clinic/ U7 out-of-clinic
Behavioral Health Assessment H0031 U3	$30.01 per 15 minutes in clinic/ $36.68 per 15 minutes out-of-clinic
Nurses Assessment T1001 U3	$30.01 per 15 minutes in clinic/ $36.68 per 15 minutes out-of-clinic
Medication Administration H2010 U3 (comprehensive med management) or 96372 U3 (injection)	$25.39 per 15 minutes in clinic/ $33.01 per 15 minutes out-of-clinic
Physician Diagnostic Assessment 90792 U1 U6	$174.63 **per session** in clinic
Psychiatric Treatment E/M established patient 99214 U1 U6	$97.02 per 25-minute session in clinic
Family Outpatient Services: Family Counseling H004 HR U3	$30.01 per 15 minutes in clinic /$36.68 per 15 minutes out-of-clinic
Group Outpatient Services: Group Counseling H004 HQ U3 U6	$3.30- $8.25 per 15 minutes in clinic or out-of0clinic
Intensive Family Intervention (IFI) H0036 U3	$30.01 per 15 minutes in clinic /$41.26 per 15 minutes out-of-clinic
Individual Counseling 90837 U3	$120.04 **per 60 min session in clinic/** $146.71 **per 60 min session out of clinic**
Crisis Intervention H2011 U3	$30.01 per 15 minutes in clinic /$36.68 per 15 minutes out-of-clinic
Service Plan Development H0032 U3	$30.01 per 15 minutes in clinic/ $36.68 per 15 minutes out-of-clinic
Case Management – Adult- Individual T1016	$18.15 - $24.36 per 15 minutes out-of-clinic
Community Support – C&A- Individual H2015	$18.15 - $24.36 per 15 minutes out-of-clinic
Peer Support – Adult – Individual	$15.13 – $20.30 per 15 minutes out-of-clinic

- I affirm that the statements above are true and accurately reflect my current financial circumstances.
- I understand that I am responsible for payment for services provided to my dependents or myself.
- I understand that the organization may ask me for additional information to assist in making a final determination of my ability to pay.
- I further understand that the organization may verify the information provided and give my consent for the verification by signing this application.
- I understand that my financial status will be reviewed annually or as circumstances change.
- I also understand that I have the option to review the decision by following the review process.

_____ _____

Signature of Individual or Representative **Date**
(If a minor, parent/guardian's signature)

Please read, complete, and sign Willow Oak Financial Expectations Form