

GEORGIA DEPARTMENT OF HUMAN RESOURCES
Application for Financial Assistance for
Community Mental Health and Addictive Diseases Services

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 # _____
Last First Middle Initial (to be completed by the Provider Organization)

Address: _____

City, State & ZIP: _____

Phone Number: Home: (____) _____ Work: (____) _____

Social Security Number: _____ - _____ - _____

Method of Payment:

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

4. Insurance Company: _____

Group Number: _____ Policy Number: _____

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

5. Co-Insurance Company: _____

Group Number: _____ Policy Number: _____

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 the income of those individuals reported on your last tax return.

	Initial	Update	Update	Update
Dates of Application Reviews	Date:	Date:	Date:	Date:
	Amount	Amount	Amount	Amount
Monthly Income from Wages				
Consumer 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	Consumer Fee Amount Per Established Period

- 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 Consumer or Representative
 (If a minor, parent/guardian’s signature)

Date