Cascade
Behavioral Health

CHARITY APPLICATION

FINANCIAL DISCLOSURE FORM

Name of Patient/Guarantor Patient Account #

Social Security Number Date of Birth

Employer _____ Phone _____

Gross monthly income $_____
Any additional Source of income (child support/alimony) $_____

Total Monthly Gross Household Income (Proof of income required) $_____

Number of dependents including Self: _____

Housing: Own ____ Rent _____ Monthly payment $_____

Do you have any of the assets listed below? If so, please provide details.

Yes ___ No ___ Checking account $_____
Yes ___ No ___ Savings account $_____
Yes ___ No ___ Money Market Fund $_____

Please list any other financial information to be considered in determining your ability for payment:

_____

_____

Cobra eligible? Yes or No If yes, insurance company _____ premium _____

To receive healthcare at a reduced cost to you, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this disclosure. Completion of the Financial Disclosure Form does not guarantee that you will be eligible for a cost reduction in your healthcare.

I authorize representatives of Cascade and its affiliates to verify the information on this form and to release any of my information for payment purposes. The information given above is true and complete. I agree to notify Cascade of any changes in my financial situation. I further authorize Cascade and its affiliates to review and inquire into my credit history using any means available, including using a Credit Bureau History Report.

Signed _____ Date _____

Witness _____ Date _____