APPLICATION FOR FINANCIAL ASSISTANCE

*** Please Use Black Ink**

Patient ID#: __________

Overmountain Recovery Clinic recognizes there can be a need for financial assistance with individuals that have limited income in paying clinic bills. Eligibility for financial assistance is based on established criteria and the information contained in this application.

The purpose of this form is to collect information that will enable us to make an appropriate and fair determination of your financial needs. Please complete each item on the application and include the supporting documentation listed on page 2. It is extremely important that you complete this application upon receipt and return it to Overmountain Recovery within 10 days.

<table>
<tr><td colspan="5">Patient Name Last First Middle Initial</td><td colspan="2">Date of Birth</td></tr>
<tr><td colspan="2">Responsible Party</td><td colspan="3">Social Security Number</td><td colspan="2">Home Phone</td></tr>
<tr><td colspan="2">Address</td><td colspan="2">City</td><td>State</td><td colspan="2">Zip Code</td></tr>
<tr><td colspan="2">Employer ❑ Unemployed</td><td colspan="2">Work Phone</td><td colspan="3" rowspan="2">Is this patient account due to a motor vehicle accident or any other personal injury?
❑ No ❑ Yes
If yes, please provide the following info:
Insurance Company / attorney / person asserted to have caused injury:
____
Policy Number: ___________________________
Agent Name: ____________________________
Phone Number: ___________________________</td></tr>
<tr><td>Number in Household</td><td colspan="3">Does employer offer Medical Insurance? ❑ No ❑ Yes
If offered and you do not subscribe, please indicate reason:</td></tr>
<tr><td colspan="2">Dependent(s) - Name & Age</td><td colspan="2">Are you on disability?
❑ No
❑ Yes - How long? ___________</td><td>Are you a veteran? ❑
No
❑ Yes - Branch_____________</td><td colspan="2">Annual Gross Household Income</td></tr>
<tr><td colspan="3">Spouse's Name</td><td colspan="3">Social Security Number (spouse)</td><td>Work Phone</td></tr>
<tr><td colspan="3">Employer (spouse) ❑ Unemployed</td><td colspan="4">Does employer offer Medical Insurance? ❑ No ❑ Yes
If offered and you do not subscribe, please indicate reason:</td></tr>
</table>

APPLICATION FOR FINANCIAL ASSISTANCE

Please provide proof of all income and assets noted on this page, including items 1 - 5 (below). Your application cannot be considered without this information and will be returned to you if the information is not included with the application.

1. Current Pay Stub (Responsible party & spouse) **REQUIRED**
2. Last two complete Federal Tax Returns with profit and loss reportings **REQUIRED**
3. Checking, Savings & Health Savings Statements (one full month) **REQUIRED**
4. Copy of Food Stamp Certification letter.
5. Copy of police report if involved in motor vehicle accident.

INCOME (Monthly)

Patient	$ ______________
Spouse	$ ______________
Dependent(s)	$ ______________
Public Assistance	$ ______________
Food Stamps	$ ______________
Social Security	$ ______________
Unemployment	$ ______________
Strike Benefits	$ ______________
Worker's Compensation	$ ______________
Alimony	$ ______________
Child Support	$ ______________
Military Allotments	$ ______________
Pensions	$ ______________
Income from: Rent, Certificates of Deposit, Dividends, Interest	$ ______________
TOTAL:	**$** ______________

EXPENSES (Monthly)

Rent / Mortgage	$ ______________
Homeowner's Insurance	$ ______________
Property Tax	$ ______________
Electric	$ ______________
Gas / Propane	$ ______________
Water	$ ______________
Telephone / Cell Phone	$ ______________
Food	$ ______________
Car Payment	$ ______________
Car Insurance	$ ______________
Gasoline	$ ______________
Alimony / Support	$ ______________
Child Care	$ ______________
Clothing	$ ______________
Credit Cards (Total per month)	$ ______________
Loans	$ ______________
Medical Insurance	$ ______________
Life Insurance	$ ______________
Other	$ ______________
TOTAL:	$ ______________

ASSETS

Checking Account	$ ______________
Savings Account	$ ______________
Health Savings Account	$ ______________
Certificates of Deposit	$ ______________
IRAs	$ ______________
Investments	$ ______________
Stocks / Bonds	$ ______________
Land / Property other than home you live in	$ ______________

Vehicles	**Make**	**Estimated Value**
Auto #1	______________	$ ________
Auto #2	______________	$ ________
Motorcycle #1	______________	$ ________
Motorcycle #2	______________	$ ________
Boat	______________	$ ________
Recreational Vehicle	______________	$ ________

NOTE: If you report zero income, you must submit signed statements from individuals providing your room and board, signed statements attesting to your unemployed status and/or a signed statement explaining how your daily expenses are being covered with zero income to report.

Please list any other information you feel would be helpful to us in determining your eligibility for assistance in paying your clinic bill. Attach additional documentation, if needed

____
____
____
____
____
____
____
____
____
____

If you have any questions regarding this form, please contact Overmountain Recovery Clinic at 423-467-2883 or Toll Free 1-833-371-0509.

I understand that my alcohol/drug records are protected under the Federal Regulations governing Confidentiality of Substance Use Disorder Patient records 42 CFR part 2 and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”); 45 CFR parts 160 & 164. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records 42 CFR part 2 will continue to protect the confidentiality of the information that identifies me as a patient in an alcohol or other drug program from-re-disclosure. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in any event that this consent expires. This consent will automatically expire upon discharge from the program.

I certify I have provided complete and accurate information in this application. I understand Overmountain Recovery Clinic may verify the financial information contained in this application in connection with the clinic's evaluation process and may run a credit history to verify the above information. I hereby authorize the clinic to contact my employer to certify the information provided and to request reports from credit reporting agencies. I understand that this information will be used to determine my eligibility for financial assistance and that falsification of information in this application will result in denial of any assistance.

I also certify that, except as disclosed in this application, no third party (such as an insurance company or person who caused injury to me) may be responsible for paying for the services provided to me.

Patient / Guardian / Guarantor Signature ____Date ____________________

Rev. 07/01/2018