VETERANS RECOVERY RESOURCES

# Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Veterans Recovery Resources.

Veterans Recovery Resources is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high-quality, affordable mental healthcare services, Veterans Recovery Resources strives to ensure that the financial capacity of Veterans and service members who need mental health care services does not prevent them from seeking or receiving care. Veterans Recovery Resources will provide, without discrimination, care for emergency mental health conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

**What does financial assistance cover?** Our financial assistance covers appropriate clinic-based services provided by Veterans Recovery Resources depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

**If you have questions or need help completing this application:** Please contact our Program Coordinator at 866-648-7334. You may obtain help for any reason, including disability and language assistance.

**Note**: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number, it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

**Submit your completed application with all documentation to:**

- Mail: Veterans Recovery Resources P.O. Box 41241 Mobile, AL 36604.
- Fax (251) 405-3323.
- Email: Scan and email to info@vetsrecover.org.
- In person: Visit us: 1156 Springhill Avenue Mobile, AL 36604.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

**We want to help. Please submit your application promptly!**
**You may receive bills until we receive your information.**

# Veterans Recovery Resources
# Charity Care/Financial Assistance Application Form – Confidential

*Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.*

## SCREENING INFORMATION

Do you need an interpreter? ☐ **Yes** ☐ **No** *If Yes, list preferred language:*

Have you applied for Medicaid? ☐ **Yes** ☐ **No** *May be required to apply before being considered for financial assistance*

Do you receive state public services such as TANF, Basic Food, or WIC? ☐ **Yes** ☐ **No**

Is the patient currently homeless? ☐ **Yes** ☐ **No**

Are your medical care needs related to a car accident or work injury? ☐ **Yes** ☐ **No**

## PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we will verify and may-ask for additional information or proof of income.
- Within 30 days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

## APPLICANT INFORMATION

| First name | Middle name | | Last name |
|---|---|---|---|
| ☐ Male ☐ Female<br>☐ Other (may specify ______________) | Birth Date | | Social Security Number |
| Person Responsible for Paying Bill | Relationship to Applicant | Birth Date | Social Security Number |

Mailing Address

______________________________________________________________

______________________________________________________________

City State Zip Code

Main contact number(s)
( ) __________________
( ) __________________
Email Address:
____________________________

Employment status of person responsible for paying bill.
☐ **Employed** (date of hire: ______________________) ☐ **Unemployed** (how long unemployed: ________________________)
☐ **Self-Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other** (______________________)

## FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

**FAMILY SIZE** ___________ *Attach additional page if needed*

| Name | Date of Birth | Relationship to Applicant | If 18 years old or older: Employer(s) name or source of income | If 18 years old or older: Total gross monthly income (before taxes): | Also applying for financial assistance? |
|---|---|---|---|---|---|
| | | | | | Yes / No |
| | | | | | Yes / No |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Yes / No |
| | | | | | Yes / No |

All adult family members' income must be disclosed. Sources of income include, for example:
-Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI Child/Spousal Support Work study programs (students) - Pension - Retirement account distributions - Other (*please explain)*

## INCOME INFORMATION

***REMEMBER****: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income. Examples of proof of income include:

- W2 withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

## EXPENSE INFORMATION

*We use this information to get a more complete picture of your financial situation.*

Monthly Household Expenses:
Rent/mortgage $________________________ Medical expenses $________________________
Insurance Premiums $________________________ Utilities $________________________
Other Debt/Expenses $________________________ (*child support, loans, medications, other*)

## ASSET INFORMATION

*This information may be used if your income is above 200% of the Federal Poverty Guidelines.*

$____________________________
Current savings account balance.
$____________________________

**Please check all that apply**
□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)
□ Property (excluding primary residence) □ Own a business

## ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

## APPLICANT AGREEMENT

I understand that Veterans Recovery Resource may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

______________________________________ ________________________

Signature of Applicant Date

THIS IS THE END OF THIS FORM