## WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES?
**(Where should we send the client's statement?)**

Name ______________________________ Relationship to Client ______________

Social Sec # ______________________ Date of Birth ________________

Address ______________________________________________

City ______________________ State __________ Zip ___________-_______

Primary Phone: ______________________ Business Phone: ______________________

Name of Employer ______________________________________________

Address ______________________ City ______________ State __________ Zip ________

**DISCOUNT**
(The highest fee discount is not 0% but a $5.00 co-pay for Outpatient and a $25.00 co-pay for inpatient service.)
Percent Client Pays: ________%
Effective Date: __________

Comments: ______________________
______________________________

**PRIMARY INSURANCE**
(Check one)
__ None
__ Private Insurance
__ HIP
__ Tri-Care
__ Medicaid # ______________
__ Medicare # ______________
__ Medicare & Medicaid (write numbers above)
__ Other

**HAP ELIGIBLITY**

| | | |
|---|---|---|
| 200 % Poverty? | Y | N |
| Medicaid? | Y | N |
| Food Stamps? | Y | N |
| TANF? | Y | N |

**INCOME INFORMATION** **Monthly** Amount

**(We must have income information for all HAP clients. If a person is included in the total family size, their income should also be included in the total income amount.)**

Household wages, salaries, tips $______________

Social Security, SSI, Disability $______________

Alimony, Child Support $______________

Other (interest, rents, pensions,
Unemployment, V.A. benefits,
Self-employment income) $______________

**Income Verification for HAP clients when eligibility is based on family income and size (i.e.at or below 200% of poverty level, but no Medicaid, TANF, food stamps)**
Date Requested: __________
Date Received: __________
□ Not Currently Available

**Total Monthly Family Income** $______________ **x 12 = Yearly Income:** ______________
**Family Size** ______ **(The number of family members that depend on family income for support.)**

Please explain living situation when there is zero income: ______________________
______________________________________________

I certify that the above information is true and accurate, and accept responsibility for its accuracy.

**Client/Guardian Signature** ______________________ Date ____________

**Staff Signature** ______________________ Date ____________

Form No. 81 Rev 4/20

Name:

Client ID: DOB:

**Oaklawn Psychiatric Center**
*Client Financial Information*

Client ID Document Date