Financial Assistance Application

If you do not have insurance or your insurance does not cover your behavioral health services, complete this form to apply for financial assistance. To comply with federal regulations, it is necessary for us to ask some personal questions. Household/family size and annual income will be used to determine your eligibility and calculate your discount. Please include proof of income for each item with this application. If your income or the number of people in your family/household changes during your care, you may ask for a review of your eligibility. For support, contact our Client Accounts Representative team at 719-345-6255 or at clientaccounts@solvistahealth.org. Turn your application in to one of our office locations or clientaccounts@solvistahealth.org.

Patient Information			**Today's Date:** _____/_____/_____	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Date of Birth: / /				

Household Size & Income – List only the people who are supported by the family/household income (for example: yourself, spouse, or children). Do not list roommates or anyone who pays their own living expenses. Please include all income for the people you list. You must also include a copy of a paystub for each member who receives wages, tips, or salary, as proof of income for this section.

Name	**Date of Birth**	**Relationship**	**Income –** Before tax (wages/tips/salary)	**Frequency** (Circle One)
	/ /		$	Weekly Biweekly Monthly Bimonthly Yearly
	/ /		$	Weekly Biweekly Monthly Bimonthly Yearly
	/ /		$	Weekly Biweekly Monthly Bimonthly Yearly
	/ /		$	Weekly Biweekly Monthly Bimonthly Yearly
	/ /		$	Weekly Biweekly Monthly Bimonthly Yearly
		Total:	$	Weekly Biweekly Monthly Bimonthly Yearly

Additional Household Income – Please list any other income received by household members. Include income for all people listed in the *Household Size* section. If multiple members receive the same type of income, list each person. Attach the required proof for each income source listed.

Name(s)	**Income Source**	**Monthly Amount**	**Please attach the listed document as proof**
	Unemployment Compensation	$	Award letter or statement
	Self-Employment Income	$	Prior year income tax return
	Worker's Compensation	$	Award or determination of benefits letter
	SSDI or SSI	$	Benefit letter, statement of benefits received, notice of award
	Alimony	$	Court Decree
	Rental Income	$	Copy of lease
	Trust Fund	$	Letter from trustee

Acknowledgement

I hereby attest that I can access and view the sliding fee scale and that the information I have provided is true and correct. I understand providing false or misleading information may disqualify me immediately and I may become financially responsible. I agree to work with Solvista to provide any additional information to help make a determination. I understand that I can request a new evaluation if my circumstances change.

Name(Print): _____ Signature: _____ Date: _____