NORTHEASTERN CENTER
YOUR COMMUNITY COUNSELING CENTER

Financial Assistance Application

The Northeastern Center helps individuals achieve emotional and mental wholeness through accessible, affordable, and quality behavior health services to those in need at a sliding fee discount based on family size and income status. No one will be denied services based on inability to pay.

Applicant Name: _____ Date: _____

Name of Client if different from Applicant: _____

Address: _____ DOB: _____

_____ SS#: _____

Address: _____

List your household members, include yourself, children, and any person you claim as a dependent (you must verify dependents via tax return, copies must be attached to this application)
Please list spouse and dependents (under age 18)

Name:	DOB:	Relationship:	Verification Date/Method:
Client			
Other			
Dependent			
Dependent			
Dependent			
Dependent			
Dependent			

Do you or any household members have or have applied for Medicaid, Medicare, Disability, Social Security, or any other Federally Funded Program? ☐ Yes ☐ No If so, please list:

Name:	Insurance Coverage Name:	Policy Number:	Verification Date/Method:

I (applicant) understand that I must pay my discounted Fee Assistance amount at the time of service and pay any outstanding balances owed in order to continue on the Fee Assistance Program unless payment arrangements have been made and adhered to. (*Please initial)* _____

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FA4007
Form and Attachments
Revised 05/31/2024

Patient Name: _____
MRN: _____
Location: _____

Directions: Scan into SmartCare under Income Verification and Eligibility Determination for Financial Assistance"

DECLARATION OF GROSS INCOME **$ AMOUNT**

Wages, Salary

1) Employer:_____ _____

Employer Address:_____

2) Employer:_____ _____

Employer Address:_____

Government Benefits:

Unemployment Benefits	_____
Workers Compensation	_____
Social Security (Regular or SSI)	_____
Veterans Benefits	_____
Temporary Assistance for Needy Families (TANF)	_____
Medicaid	_____
Food Stamps	☐ Yes ☐ No

Other Income:

Dividends	_____
Rental	_____
Retirement Benefits	_____
Interest Income	_____
Pension	_____
Child Support	_____
Other	_____
TOTAL INCOME: **TOTAL**	_____

Other income can also include royalties, income from estates, trusts, educational assistance, alimony and assistance from outside the household.

Name of Medical Insurance Company: _____

Insurance ID Number: _____

Attestation:
By my signature below, I hereby certify that the above information is true and correct to the best of my knowledge and belief.

_____ _____
Client/Guarantor Signature Witness Signature

_____ _____
DATE DATE

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ATTESTATION OF FINANCIAL AGREEMENT

I (applicant) hereby declare that anyone listed on this application listed as “no income received” does not receive any income from any source. (*Please initial)* _____

I (applicant) understand that providing false information will result in termination of services and the Northeastern Center may refer documents to an appropriate federal agency for further investigation. (*Please initial)* _____

I (applicant) understand that I must renew this application annually or if there is a change in the number of people in my household or the household income status changes. (*Please initial)* _____

I certify that the family size and income information shown above is correct. I understand that copies of tax returns, pay stubs, and other information verifying income documentation is required before a discount will be approved. (*Please initial*) _____

I understand that the Center reserves the right to establish which services I am eligible for assistance and the conditions under which assistance will be granted. (*Please initial*) _____

I understand the Center charges both a professional and facility charge for all eligible services and that third party copays and deductibles may be applicable to both sets of charges. (*Please initial*) _____

I understand I may be provided services in my absence for which I am responsible for payment (e.g. treatment planning).
(*Please initial*) _____

I understand the Northeastern Center, Inc., reserves the right to use established collections procedures if I do not meet my payment responsibility. I authorize the Center and/or any entity authorized by the Center, including those using automated dialing systems, automated messages, email, text messaging and other electronic communication to contact me for any reason using any telephone number, email address and/or mailing address provided. (*Please initial*) _____

I authorize payment directly to Northeastern Center, Inc. for any third party benefits to which I am entitled. I also authorize the release of information to process third party claims. (*Please initial*) _____

I authorize Northeastern Center, Inc. to file a written complaint with the Insurance Commissioner if any insurance claim filed on my behalf isn't paid or denied within thirty (30) days of filing. (*Please initial*) _____

I understand that certain services may not be covered by my insurance, Medicare or Medicaid. I agree to accept financial responsibility for these services. (*Please initial*) _____

I understand any third party payment will be applied first to the assisted portion of my balance and any payment remaining after the assisted portion has been fulfilled will be applied to my fair share. (*Please initial*) _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Northeastern Center, including physician services. (*Please initial*) _____

I authorize holder of medical or other information about me to release to the Health Care Financing Administration and its agents, including information needed to determine these benefits for related. (*Please initial*) _____

Signature of Patient / Head of household / Guardian: _____

Printed Name: _____

Date: _____

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Signature of Northeastern Center Representative: _____

Date: _____

The following documents are required to assist in the application approval process:

- Valid Photo ID
- W-2
- Paycheck Stubs (last 30 days)
- Income Tax Returns
- Profit & Loss Statement from a self-employed business
- Forms approving or denying unemployment or worker's compensation
- Written verification of wages from employer
- Written verification from public welfare agencies or any governmental agency that can attest to the patient's income status for the past 12 months
- A Medicaid remittance voucher reflecting exhausted Medicaid benefits for the applicable Medicaid fiscal year
- Medicaid verification of the Patient Share of Cost unless otherwise noted, all documentation should be for the most recent year/period available.

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