Sieda BEHAVIORAL HEALTH AND TREATMENT SERVICES
APPLICATION FOR FINANCIAL ASSISTANCE

Person Served Name: _____ **Phone #:** (___)_____

Address: _____ **SSN:** _____
(Street / P.O. Box)

_____ **DOB**: _____
(City / State / Zip)

Mailing Address (if different): _____

_____

ANNUAL Household Income:

_____ Gross Amount (before deductions)

Income Calculations (check one):

Paid Weekly___, Every Other Week___, Twice per Month___, Monthly___
(x52) (x26) (x24) (x12)

Number of people in household supported by this income: _____

Form of verification used in determining income: _____
(Recent Pay Stub, Last Year's Tax Return, Employer Statement, Workforce Center Quarterly Statement – if registered)

Treatment Fees:
Individual Fee: _____ Group Fee: _____ IOP Fee: _____ UA Fee: _____

OWI Screening Receipt # $125.00 in state, $150.00 out of state.

Office Use: Do not write in box.

Billing Information: Check One

_____The above-named person is NOT covered by any healthcare plan and will make arrangements for payment of all treatment fees.

_____The above-named person is covered by the health plan described on the next page and understands that they are responsible for all treatment fees regardless of insurance carrier payment. In the event total payments exceed full treatment rates, the credit balance will be reimbursed to the client.

CONSENT TO RELEASE BILLING AND/OR SCHEDULING INFORMATION

I authorize Sieda Behavioral Health and Treatment Services to release the information specified below to:

Name of organization/person: _____

Address/Phone number: _____

INFORMATION TO BE RELEASED: Check All That Apply

_____Duration of program involvement and attendance, including all substance use disorder information
_____Information regarding billing for services, including all substance use disorder information
_____Information regarding scheduling for services, including all substance use disorder information

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires six (6) month after last service.

I understand that generally Sieda may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____ _____
Person Served Signature **Date** Signature of parent, guardian or authorized representative when required

_____**Person Served Received Copy** _____**Person Served Refused Copy** _____**Form Completed By (Staff Initials)**

Revised 11/17 KK