Financial Assistance Form

In order to receive care for a reduced fee from Vera French we request that you first complete the application for Medicaid and for aid from Scott County and submit the required documentation. Those same documents will be used to complete the Vera French form. As soon as the applications are submitted to Medicaid and Scott County, this application can be completed. Please bring copies of those completed forms and the supporting documentation to submit with this Vera French form.

Patient Information

Last Name:	First:	Middle:
Address:		
City:	State:	Zip Code:
Phone Number:		

How can we help?

☐ Assistance with co-pays	☐ Balance reduction
☐ One-time request	☐ Waive entire fee
☐ To cover a gap in insurance coverage	☐ Other: ______________________________

Tell us a little about yourself:

Insurance deductible amount: $	☐ Individual	☐ Aggregate
Behavioral health co-pay: $		
Monthly Household income from all sources: (as reported to Medicaid and Scott County) $		
Family size*:		
# of family members individual counseling at Vera French:		

Status of Medicaid application:	Status of Scott County application:
☐ Applied, awaiting notice of decision	☐ Applied, awaiting notice of decision
☐ Denied coverage due to: ____________________	☐ Denied coverage due to: ____________________
☐ Eligibility gap, will be covered in a month	☐ Eligibility gap, will be covered in a month
☐ Other: ______________________________	☐ Other: ______________________________

*Family size as defined by the Federal Department of Health and Human Services for Medicaid and other programs. Family size is the head of household (tax filer), spouse and dependent(s).

Other circumstances you would like us to consider:

Complete this section to request an exception to the Sliding Fee Scale
Rent:
Car payment:
Utilities (gas, water, electric):
Phone:
Child support:
Medical Costs:
Pre-existing debt payments:
Total Expenses:
Expenses as a % of income:
Please provide support to validate the expenses noted above.

I certify that the information I have provided is accurate and complete. I understand that I will be requested to update my information periodically and report any changes in insurance coverage (and Medicaid/Scott County) as soon as possible.

Patient Signature: ______________________________

Date: ______________________

FOR VF USE ONLY	
Prepared by:	Date:
Approved by:	Date:
Approved level/length of time:	