TLC TRANSITIONAL LIVING
An Agency of Community Health Alliance

SOJOURNER Life • Hope • Community
An Agency of Community Health Alliance

PATIENT FINANCIAL AGREEMENT

Sojourner Recovery Services and Transitional Living are subsidiaries of Community Health Alliance and are not-for-profit behavioral health organizations supported by patient fees, third party reimbursement, local, state and federal funds and contributions. If you have insurance benefits for behavioral health services or are eligible for third party coverage, you may find these sources will cover part or all of the costs of the services you receive. You will be responsible for co-pays, co-insurance or deductibles as directed by your insurer at the time of service. Agencies of Community Health Alliance have public funds that may be made available to persons who qualify for subsidy through the local Mental Health and Addiction Recovery Services Boards or other third party payers.

PATIENT INFORMATION

Patient Name: _____ DOB: _____

SS#: _____ Phone: _____

Address: _____ City/State: _____ Zip Code: _____

Alias/ Maiden or other Name: _____ Family/Household Size _____

MEDICAID & MEDICARE

Do you have Medicaid benefits? ☐ Yes ☐ No Medicaid #: _____

If you have Medicaid, do you have a spend down requirement? ☐ Yes ☐ No

Do you have Medicare benefits? ☐ Yes ☐ No Medicare #: _____

What type of Medicare? ☐ Type A ☐ Type B ☐ Both

COMMERCIAL INSURANCE

Do you have commercial insurance benefits? ☐ Yes ☐ No

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Subscriber Name: _____	Subscriber Name: _____
Relationship (Other than Patient): _____	Relationship (Other than Patient): _____
Insured SS#: _____	Insured SS#: _____
Phone: _____	Phone: _____
Policy Number: _____	Policy Number: _____
Group Plan Number: _____	Group Plan Number: _____
Effective Date: _____	Effective Date: _____
Co-Pay: _____ Coinsurance: _____	Deductible: _____ Other: _____
Do your benefits cover behavioral health services? ☐ Yes ☐ No	Is pre-certification required? ☐ Yes ☐ No

*You must present your insurance card.

EMPLOYMENT AND FINANCIAL SUPPORT INFORMATION

Responsible Party: _____ Relationship to Patient: _____

Responsible Party Address: _____ Responsible Party Phone: _____

_____

Employer: _____ Work Phone: _____ Gross Annual Income: $_____

Additional Financial Support and Annual Amounts:

_____ Gross Annual Income: $_____

_____ Gross Annual Income: $_____

_____ Gross Annual Income: $_____

Expenses: List Exceptional Family Expenses: Day Care, Medical expenses, child support). Must exceed 7% of total Income.

_____

Total Gross Income: $_____ _____

Total Amount of Expenses: $_____

Adjusted Annual Income: $_____

Do you have a representative payee? ☐ Yes ☐ No ☐ Individual ☐ Agency ☐ Other

Representative Payee Name: _____ Agency: _____

Address: _____ Phone: _____

Payee Relationship to Patient: _____

BOARD OR CONTRACT SUBSIDY

I understand that I am financially responsible for the cost of all services received while I am a patient of Community Health Alliance and Subsidiaries, Sojourner Recovery Services, Transitional Living. Based on my income, I may qualify for a subsidy through the local board or other contract payor based on my county of residence. In order to qualify for available funding, I am required to complete additional paperwork required by the county and provide verification of my income, insurance and proof of residency. I have received a schedule detailing the fees for each service. I agree to provide the Agency with a copy of my subsidy application and agree to pay fees based on the subsidy schedule, which is based on my income and family size. I agree to provide the Agency with information when changes occur to my income, address or insurance. I authorize the release of sufficient information, so the board can enroll me in the payment system and determine my eligibility for available public funds.

By signing this authorization, you are authorizing the release of sufficient information for enrollment in eligibility and billing claim software for your county of residence for the purpose of determine eligibility for funds and submission of claims for payment.

I understand that I may be eligible for a subsidy to be paid by the Mental Health and Addiction Recovery Services Board I the county of my residence. Such eligibility is contingent upon completion of required county forms and supporting verification.

I am responsible for paying for services in the amount of _____ or a monthly cap of $_____.

AUTHORIZATION

I understand more than one or more provider (clinician, doctor, nurse, etc.) may need to provide treatment, evaluation or consultation as clinically indicated and my invoices will reflect all services delivered by each provider. I certify the information provided in preparing this agreement is accurate to the best of my knowledge. I agree to pay the agency fees due for the cost of services incurred and to cooperate with the agency in securing reimbursement from named third party payor(s) to the extent that I am eligible. I agree I am responsible for the full cost of services not covered by my insurance carrier or other third-party payor(s) and agree to pay any portion of the fees assigned to me. I request any payment from my insurance company be paid directly to the agency. I authorize the release of information necessary such as identifying demographics, social or medical information in order to process the claims. I understand that if insurance pays directly to me, I am responsible for paying that amount to the agency. I understand such information will be managed ethically and responsibility in accordance with governing laws and regulations**. I have read or have read to me the contents of this financial agreement and I fully understand its content**.

I understand that based upon my insurance payor(s) the agency may be required to comply with state reporting regulations regarding demographic and limited treatment episode information for utilization and outcome data collection. Reporting is completed by social security number, Medicaid or County ID number for individuals with Medicaid, Medicare or other government payers.

I agree to **notify the agency within two weeks if my financial status changes**, which may affect the amount of my fees. I have been informed of the fees and instructed on how to obtain fee or rate information.

I understand this financial agreement is **effective starting today and is in effect for one year**.

Legal Guardian/Guarantor Name: _____ SS: _____

Legal Guardian/Guarantor Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Agency Representative: _____ Date: _____