

Financial Assistance Application

Park Place Behavioral Health Care 206 Park Place Blvd. Kissimmee, FL 34741
Phone: (407) 846-0023

Information & Instructions

The sliding fee scale is based on Federal Poverty Guidelines. Client fees will be based on household income and the number of people in the household. Eligibility for assistance will be considered without regard to race, color, gender, age, disability, religion, national origin, veteran status, political beliefs, sexual orientation, marital status, a/o any other characteristics or trait which sets an individual apart from others and may be construed to be used to provide less than equivalent treatment.

The financial assistance program is offer only for the residents of Osceola County.

Currently the financial assistance may cover the followings:

- Psychosocial Evaluation (initial evaluation)
- Psychiatric Evaluation (evaluation for medication management)
- Medication Management Follow-ups (15 or 30 minutes visits)
- Children Individual Therapy (3 to 17 years old)

This application needs to be completed and all documents attached to it if you wish to be consider for assistance. Without adequate documentation, your request may be refused. All clients who benefit from reduced fees are required to immediately notify PPBHC of changes of income a/o household size by calling PPBHC at (407) 846-0023 ext. 1069 or making an appointment to see the "Financial Specialist" to continue eligibility for reduced fees, you will be asked to update your information every 6 months.

Documents required to process financial assistance for a **child**:

Proof of Identity.....Acceptable documents (all are required, if apply):

- Parent/Legal Guardian valid driver license or state picture identification card
- Child original social security card
- If the child is adopted- adoption papers required.
- If the child is a foster child- temporary custody papers from the state required.
- If the child is under the care of an adult, not the natural parents-current affidavit or legal custody papers issued by the state are required.

Proof of Income.....Acceptable documents (all are required, if apply):

- Last four pay stubs or letter from employer stating salary and working hours for the parent/legal guardian of the child.
- If the parent/legal guardian is not currently working and depends from somebody else for basic needs, letter from the caregiver is needed to verify dependency.
- If the parent/legal guardian receives social security, unemployment, or any other benefits; the original benefit award letter or copies of the most recent benefit check or deposit record for the parent/legal guardian a/o all members receiving benefits are required.

Address Verification.....Acceptable documents (all are required, if apply):

- Original utility bill (electric, water, cable, phone, lease agreement, or mortgage paperwork) for the parent/legal guardian of the child required.
- If the parent/legal guardian depends on somebody else for basic needs, utility bill (electric, water, cable, phone, lease agreement, or mortgage paperwork) from the caregiver and letter attached to this application completed is required.

Documents required to process financial assistance for an **adult**:

Proof of Identity.....Acceptable documents (all are required, if apply):

- Valid driver license or state picture identification card
- Original social security card.
- Original social security for all claimed dependants.

Proof of Income.....Acceptable documents (all are required, if apply):

- Last four pay stubs or letter from employer stating salary and working hours.
- If the applicant receives social security, unemployment, or any other benefits; the original benefit award letter or copies of the most recent benefit check or deposit record for the applicant a/o all members receiving benefits are required.

Address Verification.....Acceptable documents (all are required, if apply):

- Original utility bill (electric, water, cable, phone, lease agreement, or mortgage paperwork) for the applicant.
- If the applicant depends on somebody else for basic needs, utility bill (electric, water, cable, phone, lease agreement, or mortgage paperwork) from the caregiver and letter attached to this application completed is required.

Medicaid's Letter Of Application.....**If you do not have insurance and you are an Osceola County Resident; you must provide the letter from Medicaid showing that you have applied for benefits. You will then be eligible for our financial assistance program for Medications and Counseling.**

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Client Name *(Last, First)* _____ Date of Birth _____ Social Security Number _____

If the client is less than 18 years of age, complete the following information:

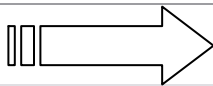
Parent/Legal Guardian's Name _____ Relationship _____ Date of Birth _____ Social Security Number _____

Parent/Legal Guardian's Address _____ City, State Zip Code _____ Home Phone # _____

Please provide the following information for all persons living in the client's household:

	<u>Name</u>	<u>Age</u>	<u>Relationship to client</u>	<u>Monthly Income \$</u>
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
6.				\$

Household Income

<u>Source</u>	<u>Monthly Amount \$</u>	<u>Source</u>	<u>Monthly Amount \$</u>
Alimony Received	\$	SSI (Supplemental Security Income)	\$
Child Support Received	\$	TANF (Temp. Asst. Needy Fam.)	\$
Food Stamps	\$	Unemployment	\$
Pension/Retirement Funds	\$	Wages, Salary, Tips, etc.	\$
SS Disability	\$	Worker's Compensation	\$
SS Retirement	\$	Other Income	\$
		Total <u>Monthly</u> Income	\$
		Total <u>Annual</u> Income	\$

Certification

I hereby certify that all information I provide to Park Place Behavioral Health Care is true to the best of my knowledge and beliefs. I understand that in accordance with Florida Statutes Section 817.50 providing false information to defraud a healthcare provider for the purpose of obtaining goods and services is a second-degree misdemeanor. I authorize all banks, employers, and/or financial institutions to disclose financial information concerning me to authorized representatives of Park Place Behavioral Health Care.

Client Signature _____ Date _____ Parent/Legal Guardian Signature _____