HORIZON
www.horizonbh.org

FINANCIAL ASSISTANCE APPLICATION

Horizon Behavioral Health offers financial assistance to help clients who are unable to pay the full cost of services. You may qualify for a discount toward your Behavioral Health services if:

- You do not have health insurance, or your health insurance does not cover all of the care you need
- You meet the following financial criteria:

Family of 1, with an annual gross household income	below $ 38,539
Family of 2	below $ 52,197
Family of 3	below $ 65,858
Family of 4	below $ 79,519
Family of 5	below $ 90,900
Family of 6	below $106,841
Family of 7	below $120,502
Family of 8	below $134,163

In order to qualify for a reduction in out-of-pocket costs, please provide the following proof of total gross family income: *(Documentation must be no more than 3 months old, or more current proof will be requested.)*

- Four current consecutive paystubs,
  or a typed Letter from Employer (on employer letterhead) stating rate of pay & hours worked per week
- Social Security Income
- Other documentation that explains current household gross income
- Copy of insurance/Medicaid enrollment or denial notice (if applicable)

DO NOT SUBMIT THIS APPLICATION UNLESS YOU HAVE ATTACHED ALL DOCUMENTATION NEEDED. ALL INFORMATION MUST BE RETURNED AS SOON AS POSSIBLE, OR YOU WILL CONTINUE TO BE RESPONSIBLE FOR CHARGES IN FULL.

Client Name: _____ Client Date of Birth (MM/DD/YYYY): __ __/__ __/__ __ __ __

Address: _____ Home Phone #: (_____)_____

City, State, ZIP: _____ Cell Phone #: (_____)_____

Please list all household members for whom you are financially responsible, excluding children 18 and over:

First and Last Name	Date of Birth	Relationship	Medical Insurance

Please see reverse side to continue application…….

Medicaid Statement:

Please check the appropriate statement boxes. Attach copies of DSS enrollment or denial notice if applicable.

I/We ([ ] have / [ ] have not) applied for Medicaid, Children's Health Insurance Program (CHIP), or other health insurance to cover these services.

- ❑ I/We have been approved, Effective Date _____.
- ❑ I/We have been denied by Medicaid, Children's Health Insurance Program (CHIP), or other health insurance. Please include a copy of denial with application.

Client or Parent Gross Income: $_____ weekly/bi-weekly/semi-monthly/monthly or, Check if Unemployed: ❑

Name of person who receives this income _____ Client or Parent Employer: _____

Spouse/2nd Parent Gross Income: $_____ weekly/bi-weekly/semi-monthly/monthly or, Check if Unemployed: ❑

Spouse or Parent Name: _____ Spouse or 2nd Parent Employer: _____

Other Income, including SSI/ Social Security/Child Support

Who receives this income _____ Source _____ Gross Amount: $_____ Frequency_____

Who receives this income _____ Source _____ Gross Amount: $_____ Frequency_____

Who receives this income _____ Source _____ Gross Amount: $_____ Frequency_____

Who receives this income _____ Source _____ Gross Amount: $_____ Frequency_____

PLEASE RETURN THIS FORM AND ALL SUPPORTING DOCUMENTS TO THE FOLLOWING ADDRESS:

Horizon Wellness Center – Landover
ATTN: Sandra Fuqua / Roberta Little
2235 Landover Place
Lynchburg, VA 24501
(434) 847-8000

*** An Eligibility Specialist may contact you to assist with an application for potential Medicaid and/or health insurance coverage ***

I understand that this application is confidential and will be used to determine my eligibility for Financial Assistance, according to Horizon Behavioral Health's guidelines. If any information that has been given proves to be untrue, I understand that Horizon may re-evaluate my financial status and take whatever action becomes appropriate.

Application Completed By (Signature): _____ Date: ____/____/____

(Printed Name): _____

Reviewed by Reimbursement Staff: _____ Date: ____/____/____