# FINANCIAL DATA SHEET

(Provider Agency Name):_____
(Provider Agency Address):_____
(Provider Agency City/State/Zip):_____
(Provider Agency Telephone Number):_____

Please print or type

1. Case Number:
2. Social Security #: - -
3. _____
   Last Name First Name Middle Name
4. Address:

5. Parents/Guardian: (Name and Address)

6. Phone #:
7. Date of Birth:
8. Race: ( ) White ( ) Black ( ) Indian ( ) Other
9. Sex: ( ) Male ( ) Female
10. Marital Status:

| 11. Family Members w/Income (Name) | Employer (Reason if none) | Gross Income: Wk. Mo. Yr. | Documentation: Y N |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

12. Number Dependents:
    Adults (self included):
    Children:
    Total Number:

13.

| | |
|---|---|
| Total Gross Income: | |
| Taxes: | |
| Income after taxes: | |
| Other Income | |
| Total Income | |

14. Explanation of Deductions:

| | |
|---|---|
| Deductions: | |
| Medical Expenses: | |
| Other: | |
| Total Deductions: | |
| Total Adjusted Income: | |

15. Established Fee:

16. HEALTH INSURANCE COVERAGE

| No Coverage | Medicaid | Medicare | Champus | BC/BS | Other |
|---|---|---|---|---|---|
| Company | Company | Company | Company | Company | Company |
| Policy # | Policy # | Policy # | Policy # | Policy # | Policy # |
| Policy Holder | Policy Holder | Policy Holder | Policy Holder | Policy Holder | Policy Holder |
| Relationship | Relationship | Relationship | Relationship | Relationship | Relationship |
| Carrier Code | Carrier Code | Carrier Code | Carrier Code | Carrier Code | Carrier Code |

## Financial Agreement

I authorize the release of any information concerning my case to any third party payor listed above. I further authorize payment of insurance benefits directly to Cumberland County Mental Health Center for service provided to me.

I certify that the information provided on this application is a true and accurate statement of my present financial status and that if this status changes, I will notify the Mental Health Center for a fee re-evaluation.

I fully understand if I fail to uphold my payment arrangements, the Mental Health Center has the authority to take appropriate actions to pursue collection of any unpaid balance due from me.

This financial information is true and complete to the best of my knowledge.

_____ _____
Interviewer's Signature Client Signature/Responsible Party

Date _____

Initials _____

Additional Client Financial Information

I understand that fees for service(s) may include: Assessment, Medication, or Physiciatric Evaluations; Group, Individual and Family Therapy.