DAVIS BEHAVIORAL HEALTH
Community • Commitment • Change

Davis Behavioral Health Date:

SPECIAL FINANCIAL ADJUSTMENT APPLICATION

Client Name: Client #:

Instructions:

To be considered for special financial adjustments, this form must be completed in full.

Please attach all documentation that applies to you
- Bank statement for 2 months if using direct deposit.
- Copies of or employer summary of payroll check stubs *(for the previous 3 months)*
- Copies of all bills that verify monthly expenses
- Two years of income tax returns for those who are in business for themselves
- Provider recommendation

Client Application

Responsible Party Name: Marital Status:

Address: City: State: Zip Code:

Social Security #: Birth Date: Phone #:

Spouse's Name:

Members in Household Dependent on my Income

Name	Age	Relationship	Name	Age	Relationship

Assets *(reasonable estimate are acceptable)*

Cash/Checking	$	Savings	$

Monthly Income Information *(All income must have verification)*

Earned Income	*Responsible Party*	*Spouse*
Total wages or Pension *(after deductions)*	$	$
Social Security/Disability Income	$	$
Alimony/Child Support	$	$
Public Assistance/Welfare/Food Stamps	$	$
Other *(please list)*:	$	$

Monthly Income Totals [1] *for office use only*	$	$

Monthly Payments

Property	*Value*	*Balance Due*	*Monthly Payment*
Residence: ☐ Rent ☐ Own	$	$	$
Property Payment Subtotal [2] *for office use only*	$	$	$

Vehicles	*Make/Model*	*Year*	*Value*	*Balance Due*	*Monthly Payment*
Vehicle #1			$	$	$
Vehicle #2			$	$	$
Vehicle Payment Subtotal [3] *for office use only*			$	$	$

Medical Expenses (if more lines needed attach on separate sheet)			
Hospital/Physician/Medical/Provider/ Pharmacy	*Amount Insurance will pay*	*Balance Due*	*Monthly Payment*
	$	$	$
	$	$	$
	$	$	$
Medical Payment Subtotal [4] *for office use only*	$	$	$

Charge cards/revolving credit/bank loans/furniture rentals (if more lines needed attach on separate sheet)			
Name of Creditor	*Purpose of Charge*	*Balance Due*	*Monthly Payment*
		$	$
		$	$
		$	$
Revolving Credit Subtotal [5] *for office use only*		$	$

Utilities					
	Monthly Payment		*Monthly Payment*		*Monthly Payment*
Heating Fuel	$	Electric	$	Water/Garbage	$
Phone	$	Cable TV	$		$

Other Monthly Expenses			
	Monthly Payment		*Monthly Payment*
Food	$	Auto Insurance (for 6 months)	$
Health Insurance (if not deducted automatically from paycheck)	$	Other *(please specify)*:	$
Utilities and Other Monthly Expenses [6] *for office use only*			$

****This Box is For Office Use Only****

Monthly Finance Statement

Total Income [1]		Other Required Payments [5]	
Rent/Housing [2]		Other Monthly Expenses [6]	
Vehicle Expenses [3]		Total Expenses [2+3+4+5+6 = 7]	
Monthly Medical Expenses [4]		Spendable Funds [1-7]	

Patient Conditions and Comments

Have you ever filed for bankruptcy? ☐ No ☐ Yes If yes, Year:_____
If yes, was DBH included? ☐ No ☐ Yes

How much can you pay each month for DBH treatment services? $_____

How much more can you pay each month towards your past account balance? $_____

Have you applied for Medicaid and been denied or found to be ineligible? ☐ Yes ☐ No
Please explain your answer:

Have you asked for assistance from your family? ☐ Yes ☐ No
Please explain your answer:

Have you asked for assistance from your clergy/church? ☐ Yes ☐ No
Please explain your answer:

Any additional comments:

Information written on this form is true and complete. I am giving added papers to prove the form information is current and accurate. I know that if the information I gave is not true or not complete I will not get help on my account and I will have to pay my whole balance. I know that filling out this form is not a promise from DBH of any help with my balance.

Print Name Signature Date