

PSYCHIATRIC SOLUTIONS, INC.



Un-sponsored Services Application

Patient Name _____

Patient Number _____

(Administrative Use Only)

Is the patient eligible for Medicare? Y or N

Medicaid? Y or N

Other Government Assistance? Y or N

For the admission beginning: _____/_____/_____

Estimated Charges	_____
Less: Estimated Deductible	_____
Less: Estimated Co-pay	_____
Less: Estimated Coverage	_____
Less: Estimated Self-Pay Portion	_____
Estimated Un-sponsored Care	_____

Monthly Household Income	_____
Less: Monthly Household Expense	_____
Monthly Disposable Income	_____

Ratio of Expenses to Net Income _____

Other Available Assets (net of liabilities) _____

For the admission beginning on _____, an exception to the admitting financial policy of Psychiatric Solutions, Inc. has been approved by the CEO, CFO or their designee based on the financial information the patient / guarantor has provided, in the estimated amount of \$_____ for un-sponsored care.

Approved

(Portion to be signed by Patient)

For the admission beginning on _____, I am unable to pay this amount or am unable to agree to an acceptable monthly payment plan and request un-sponsored care in the amount of \$_____.

Patient / Guarantor