Riverside Center for Behavioral Medicine

Application for Charity or Discount Services

Patient Name:_____

Patient Social Security #:_____

Guarantor Name:_____

Guarantor Social Security #:_____

INCOME

	Patient/ Annual Income	Spouse
1.Gross Wages & Salary/Year (before deductions)	$_____	$_____
2.Self Employment Income (per year)	$_____	$_____

OTHER INCOME

3.		
a. Interest & Dividends	$_____	$_____
b. Real Estate Rentals & Leases	$_____	$_____
c. Social Security	$_____	$_____
d. Alimony	$_____	$_____
e. Child Support	$_____	$_____
f. Unemployment/ Disability	$_____	$_____
g. Public Assistance	$_____	$_____
h. Any Other Sources	$_____	$_____
Total Income(add lines 1-3h)	$_____	$_____

EXPENSES

4. Medical Expenses (within past 12 months)	$_____	$_____

ASSETS

5.	Purchase Value	Current Value
a. Home	$_____	$_____
b. Property	$_____	$_____
c. Retirement Plan	$_____	$_____
d.Investments/Other	$_____	$_____
e.Checking&Savings	$_____	$_____
f. Life Insurance	$_____	$_____
g. Vehicles	$_____	$_____
Total assets	$_____	$_____

Applicant General Information

Patient/Guarantor Employer Name and Position within company:

_____
_____

Patient/Guarantor Employer's Address and Telephone number of Contact Person:

_____
_____

Spouse Employer Name and Position within the company:

_____
_____

Spouse Employers Address and Telephone number of Contact Person:

_____
_____

Family Status **(list all dependents that you support)**

Name	Age	Relationship

Federal Poverty Level Guidelines as of 1/24/07

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 10,210	$ 12,770	$ 12,270
2	13,690	17,170	15,750
3	17,170	21,470	19,750
4	20,650	25,820	23,750
5	24,130	30,170	27,750
6	27,610	34,520	31,750
7	31,090	38,870	35,750
8	34,570	43,220	38,750
For each additional Person add:	3,480	4,350	4,000

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Riverside Center for Behavioral Medicine to verify any information listed in this application. We grant permission to contact my/our employer.

_____ _____

Signature of Patient/Guarantor Date Signature of Spouse Date