ASAC FINANCIAL INFORMATION SHEET

Date: _____

The Area Substance Abuse Council receives funding from the State of Iowa and the United Way of East Central Iowa to help make our services affordable to everyone regardless of income. You will not be denied services because of inability to pay. However, we do require proof of income to adjust your fee. In order to determine your ability to pay for our services, we need you to fill out the attached form to the best of your knowledge. **FAILURE TO COMPLETE THIS FORM WILL RESULT IN THE FULL FEE BEING CHARGED.**

FULL LEGAL NAME _____ _____

(LAST) (FIRST) (MIDDLE) (MAIDEN) SOCIAL SECURITY NUMBER

COMPLETE MAILING ADDRESS _____

(ADDRESS) (APT#) (CITY) (STATE) (ZIP)

_____ PHONE _____ _____ _____

DATE OF BIRTH **HOME** **WORK** **CELL**

PLEASE FILL IN ALL INFORMATION. PLEASE PRINT LEGIBLY.

Is this assessment due to an OWI/DUI/Zero Tolerance charge (will you want your license reinstated) Yes [ ] No [ ]

If yes, county of arrest _____ Is this a new OWI/DUI/Zero Tolerance charge Yes [ ] No [ ] if not, have you been seen at our agency before for this OWI/DUI/Zero Tolerance charge? Yes [ ] No [ ]

Driver's license number <u>if different</u> than your social security number: _____

Female [ ] Male [ ] Marital Status: Married [ ] Divorced [ ] Single [ ] Separated [ ] Widowed [ ]

Co-habitate [ ] Employment Status: Full time [ ] Part time [ ] Not employed [ ] Retired [ ] Military [ ]

Currently on SSDI [ ] Previously on SSDI [ ] Full time college student [ ] Part-time college student [ ]

Current gross individual/household income source(s)
(if you haven't any source of income, please list your means of support)

GROSS MONTHLY/YEARLY INCOME

Income from: Name of employer: _____

Gross salary per month/year _____

Monthly unemployment received _____

Monthly workman's compensation _____

Monthly veteran's benefits _____

Monthly Social Security/retirement _____

Monthly supplemental Social Security disability income _____

Monthly AFDC/FIP _____

Monthly child support/alimony <u>received</u> _____

Other means of financial income (monthly) _____ _____

Spouse/significant other income (monthly) _____ _____

Earnings from savings/investments, etc. (monthly) _____ _____

Total gross household monthly/yearly income _____

Number of children supported by the above income _____ Number of adults supported by the above income _____

Total Number Supported _____

PLEASE FILL IN ADDITIONAL INFORMATION ON REVERSE SIDE.

Title 19/medicaid coverage Yes [ ] No [ ] Title 19/medicaid ID # _____

Have you applied for Title 19 for yourself in the last two months Yes [ ] No [ ]

Were you denied Title 19 in the last two/three months Yes [ ] No [ ]

Health/medical insurance Yes [ ] No [ ] Does it cover ASAC services? Yes [ ] No [ ] If insurance is through an employer, name of employer and local _____If insurance is under someone else:

_____ _____ _____

NAME DATE OF BIRTH RELATIONSHIP TO YOU

Insurance ID# _____ Subscriber SS# _____ Plan # _____Group # _____

Subscriber address (if not the same as yours) _____

Enter this information only if insurance card not available

Name of insurance company _____ Phone _____

Insurance company address _____

_____

Second insurance coverage Yes _____ No _____ Does it cover ASAC services? Yes _____ No _____ If insurance is through employer, name of employer and local _____If insurance is under someone else:

_____ _____ _____

NAME DATE OF BIRTH RELATIONSHIP TO YOU

Insurance ID# _____ Subscriber SS# _____Plan # _____ Group #_____

Subscriber address (if not the same as yours) _____

Enter this information only if insurance card is not available.

Name of insurance company _____ Phone _____

Insurance company address _____

_____

If we will be billing your insurance and/or Medicaid, for payment authorization, please sign below.

I authorize payment of insurance and/or Medicaid benefits directly to the Area Substance Abuse Council for services rendered by them.

_____ _____

Client **S**ignature Date

****

Office use only

OWI/Zero Tolerance Yes___ No___ Evaluation source of pay: Primary_____ Other _____

Admit source of pay: Primary_____ Other _____

Health insurance: Yes _____ No ___ Does insurance cover substance abuse treatment: Yes ____ No _____

Insurance company needs to be contacted prior to admission Yes ____ No _____ Copy given to Insurance Liaison _____

Income from SSI or SSDI: _____

Income documentation received: Yes _____ No _____ Annual income used for sliding fee calculation $_____

Comments: _____

_____

Referral source _____ Counselor Name_____