Southern Minnesota Behavioral Health
Application for Financial Assistance

Scn_____
EHR______

Southern Minnesota Behavioral Health will work with you to help you meet your obligations to pay for and continue to receive services. Please complete and sign this application, check the appropriate boxes below, and include all necessary documentation. If you qualify, you must first apply for an assistance program discount. All information provided here will be kept confidential.

Client Name:		**Date of Birth**	
Address:		**County**	
Phone:	**Circle:** Home Cell Work	**Balance: $**	**As of (date)**
Case Manager Name (if applicable):		**Phone:**	

☐ **Part 1 - Payment Plan Request**

A payment plan with Southern Minnesota Behavioral Health may be available to you. A portion of your outstanding balance is required each month, in addition to payment for current services on your appointment days. Payment plans must provide for payment in full within six months or less of the service date. Appointments will continue to be scheduled only if payment on your plan and your current balance are up to date.

Past due balance $________ Monthly payment required $_________ for ______ months

I agree to this payment plan and will submit my first payment with the return of this agreement.

Client/Guardian Signature____ Date________________________

☐ **Part 2 - Uninsured Discount Request:**

If you do not have health insurance, do not qualify for the assistance programs and your household income is less that $125,000.00 per year, you may qualify for an uninsured discount. Please attach a **current tax return** and a **letter from your employer** that proves you are not insured. If you are not employed, please attach documentation that you do not qualify for Medical Assistance or MN Care. **Please note: No authorizations will be given prior to receiving the proper documentation.**

I would like apply for reduced fees under the Southern Minnesota Behavioral Health Uninsured Discount Program. I have attached the required documentation and I agree to pay in full any balance due for services.

Client/Guardian Signature ___________________________________ Date____________________________

☐ **Part 3 – Request for Formal Review based on Unusual Circumstances:**

If none of the above meets your financial needs and you feel that you have unusual circumstances, please attach a signed letter of explanation along with documentation. Note whether you have visited the county in which you reside to apply for Medical Assistance or other programs which may be offered. You should include a proposal of a payment arrangement that meets your ability to pay. Your request will be reviewed and a response mailed to you within 10 business days.