Assistance Qualification Form

Date: _____

PLEASE PRINT

Name: _____ Age: _____ Gender: ____

Address: _____

City: _____ State: _____ Zip: _____

Contact Number: Primary: _____ Secondary: _____

Proposed: ☐ Partial Assistance ☐ Full Assistance

Treatment Proposed: _____

Check Recipient: _____

Cost $ _____ per _____ Total Cost: $ _____ ☐ None

Please Provide the Following REQUIRED forms:

☐ Letter from professional ☐ Letter from potential candidate

☐ Release of information ☐ Psychosocial, H&P, Current Progress Notes

☐ Financial Statement

☐ Discharge summary (if recently released from treatment)

Do Not Complete Below: ANONYMOUS HANDS:

☐ Request for Primary Treatment

- ☐ Suggested Treatment Provider is certified by the State
- ☐ Suggested Treatment Provider is providing a discount of: ____%

☐ Suggested Treatment Provider provides an aftercare program

☐ Applicant has established Financial Need

☐ Applicant has credible diagnosis of substance abuse

☐ Clear indication of family support and willingness to participate

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Amount of Service (# OR Duration): _____ Total Cost: $ _____
(Further assistance may be applied for, pending quality of participation and level of need.)

Board Member Approval: Date Contacted: _____

1. Name: _____
2. Name: _____
3. Name: _____

HOUSEHOLD FINANCIAL STATEMENT

Date of Application: _____

All questions of this form must be answered in full. If the question is not applicable, write "None". If additional space is needed for any answer, an attached sheet may be submitted. Information contained herein is confidential and only available to the Anonymous Hands for Recovery Review Committee.

Name: _____ SSN: _____

Spouse: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Phone: (___)_____ No. of children living with you: _____

Occupation:_____ Spouse's Occupation:_____

Employer: _____Phone: (___)_____

Address: _____

City: _____ State: _____ Zip: _____

Spouse's Employer: _____Phone: (___)_____

Address: _____

City: _____ State: _____ Zip: _____

Health Insurance: Coverage: Yes [ ] No [ ]

Provider:_____ Cert No: _____

Spouse's Health Insurance: Coverage: Yes [ ] No [ ]

Provider:_____ Cert No: _____

Gross Weekly income from all sources or copy of your most recent 1040. (If married, please combine)

Base pay from salary, wages	$
Income from commissions, bonuses, etc	$
Dividends and Interest	$
Income from trust or annuities	$
Pensions and retirement funds	$
Social Security	$
Disability, unemployment ins., workers comp	$
Public assistance (welfare, etc)	$
All other sources (rent, alimony, child support)	$

Gross Yearly income from prior year $

Assets

Real Estate

Location: _____

Fair Market Value $_____ less Mortgage $_____ = Equity $

IRA, Keogh, Pension, Profit Sharing, Other Retirement Plans $

Tax Deferred Annuity Plan(s) $

Life Insurance: Present Cash Value $

Savings/Checking Accounts, Money Market & CD's

Financial Institution and Account Number

_____ $

_____ $

_____ $

Automobiles

Fair Market Value $_____ less Auto Loan $_____ = Equity $

Fair Market Value $_____ less Auto Loan $_____ = Equity $

Other (e.g. Personal Property, Securities, etc.)

_____ $

_____ $

_____ $

Expenses (Monthly)

Rent: $_____	Heat/Electricity: $_____	Transportation: $_____
Food: $_____	Medical: $_____	Miscellaneous: $_____
Phone: $_____	Other: $_____	Health Insurance: $_____

Total Monthly Expenses $_____

Liabilities

Total Amount Due $_____ Total Monthly Payment $_____

I certify under the penalties of perjury that my income and expenses, assets, and liabilities as stated herein are true to the best of my knowledge and belief. I have carefully read this financial statement and I certify the information is true and complete.

Date: _____ Signature:_____

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

NAME:_____ DOB: _____ SS#:_____

ADDRESS: _____

_____ (___)_____

CITY STATE ZIP PHONE

THIS AUTHORIZES _____

TO RELEASE AND TO RECEIVE THE FOLLOWING PATIENT HEALTH INFORMATION:_____

_____

TO: NAME:_____ AGENCY: ____Anonymous Hands for Recovery

ADDRESS: 2101 Magnolia Ave South, Ste 518_____

Birmingham AL 35205

CITY STATE ZIP

(205___) 767-7552 (205) 251-7760

BUSINESS PHONE BUSINESS FAX

FOR THE FOLLOWING PURPOSE: ____to establish necessity of financial assistance, case management and patient progress during and after treatment

_____

I understand that I have authorized the release of my patient health information (as listed above). I understand that I may revoke this consent at any given time by giving written notice to Anonymous Hands for Recovery except to the extent that action has been taken in response to this authorization. If no prior notice of revocation is received, this consent will expire automatically one (1) year from the date this authorization is given. I understand that the confidentiality of this information is protected by Federal and State Law(s) and cannot be re-released without my written consent.

This authorization for release of the above information is fully understood and is made voluntarily on my part:

_____

Patient Date

_____

Parent/Guardian (Custodial or Responsible or Other)* Date

_____

Witness Date

Notarized: (If Applicable)

State of:_____County of:_____

My Commission Expires: _____

Sworn to and subscribed before me on this day____of_____, 20_____.

_____

Notary Public Signature

NOTICE TO RECEIVING AGENCY/FACILITY/PERSON:

This information has been released to you from patient records protected by Federal Confidentiality Regulations (42 CFR Part 2). The Federal regulations prohibit you from making any further disclosure of this information unless further release is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other patient identifying information or subpoena is NOT sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.