TURQUOISE LODGE HOSPITAL **Avatar Case No** _____

SLIDING FEE ELIGIBILITY DETERMINATION AND PAYMENT CONTRACT **TL Case No** _____

CONFIDENTIAL

Patient's Name_____ Date of Adm_____ Date of Discharge _____

APPLICANT'S STATEMENT:

SECTION A.

Mailing Address _____

City_____ **State**_____ **Zip**_____ **Phone** _____

SECTION B.

Marital Status: Married ___ Single/Never Married ___ Separated ___ Divorced ___ Widowed ___

Head of Household? Yes ___ No ____ **Gender:** Male ___ Female

SECTION C.

Your Social Security No. _____ Date of Birth _____

Do you have Health Insurance? Yes ___ No ___ If yes, complete the following:

Name of Insurance Company _____

Address _____

Policy No._____ Group No._____ Ind. No. _____

Has this party been contacted? Yes___No____By Whom? _____

Approved Denied What are payment arrangements?

Do you have any other insurance or coverage through **Spouse**, **Employer**, **Union**, **Agency**, **Tribal** or **Government Program**, etc?

Yes No If yes, complete the following:

Name of "Other" _____

Address _____

Has this party been contacted? Yes No By Whom? _____

Approved Denied What are payment arrangements?

SECTION D. (Needs to be filled out completely)

Are you: Un-Employed ___ Employed: Full-Time ___ Part-Time___Weekly Hours ____

Retired___ Other (Specify) _____

_____

(Present Employment) (Your Occupation) (Mo. Salary)

If unemployed, how long?_____ Reason _____

Where is spouse employed?_____

(Mo. Salary)

SECTION E. Please fill out all information (N/A if not applicable)

Indicate household's Gross Monthly Income from: Retirement Pension $ _____

Alimony $_____ SS (SSI or SSD)$_ Self Employment $ _____

Veteran's Pension/COMP $_____ Welfare $_____ Food Stamps $ _____

Investments or Interests $_____ Child Support $ _____

Unemployment Insurance $_____ Other (Specify):_____ $ _____

Did you file an income tax return for last year? Yes No

(If **"No"** but they did work part of this year, they will need to send a copy of income tax or their last paycheck stub for financial assistance.

SECTION F.

Income Recapitulation for Applicant and All Household Members

NAME OF HOUSEHOLD MEMBERS	SEX	BIRTH DATE	RELATIONSHIP
Applicant:			

Are you paying Child Support? Yes No Amount of Child Support Paid? _____

Total Annual Household Income Before Deductions _____
(Should Equal 12 Times Total of Sections D. & E.)

SECTION G. (To Be Read By Or To Applicant Before Signing)

Being fully aware that to deliberately withhold information or to give false information to obtain assistance for which I am not eligible may subject me to prosecution for fraud and the legal penalties applicable thereto, I, the undersigned applicant, do hereby certify that I

- ☐ (am) a resident of New Mexico, that the foregoing information is complete, true and correct to the best of my knowledge. I agree to provide documentation necessary for verification; otherwise I am responsible for all charges.
- ☐ (am not) a resident of New Mexico, that the foregoing information is complete, true and correct to the best of my knowledge. I agree to provide documentation necessary for verification; otherwise I am responsible for all charges.

I hereby authorize Turquoise Lodge and/or its employees to release information regarding my treatment for drug or alcohol abuse and mental health problems as is necessary for processing my Third Party Reimbursement Claim to the parties identified in foregoing Sections C And D. I understand that this authorization remains valid until settlement of the claim by the third party or denial of payment is received (per CFR 42).

Applicant's Signature_____ Date _____

Parent or Guardian Signature_____ Date _____

Staff Signature_____ Date _____

I, the undersigned, hereby agree to pay the charges for my treatment at Turquoise Lodge Hospital per the above payment plan. These charges will be based on established rates for treatment services and as reduced by Third Party Reimbursement, if any, and/or Certification of Eligibility for Financial Assistance as determined in the foregoing.

I understand that Turquoise Lodge Hospital does not have the authority to forgive debts owed to the State of New Mexico, and hereby authorize the acknowledgment of my account with Turquoise Lodge Hospital to their Designated Credit and Collection Representative to allow for collection of delinquent accounts.

Patient's Signature_____ Date _____

Parent or Guardian Signature_____ Date _____

Staff Signature_____ Date _____

SECTION H. (For Internal Use Only - Turquoise Lodge Hospital)

(Complete after financial information is received)