Davis Behavioral Health
HARDSHIP WAIVER APPLICATION

Date:

Client Name: Client #:

Instructions:

To be considered for special financial adjustments, this form must be completed in full.

Please attach all documentation that applies to you
- Bank statement for 2 months if using direct deposit.
- Copies of or employer summary of payroll check stubs *(for the previous 3 months)*
- Copies of all bills that verify monthly expenses
- Two years of income tax returns for those who are in business for themselves
- Provider recommendation

Client Application

Responsible Party Name: Marital Status:

Address: City: State: Zip Code:

Social Security #: Birth Date: Phone #:

Spouse's Name:

Members in Household Dependent on my Income

Name	Age	Relationship	Name	Age	Relationship

Assets *(reasonable estimate are acceptable)*

Cash/Checking	$	Savings	$

Monthly Income Information *(All income must have verification)*

Earned Income	*Responsible Party*	*Spouse*
Total wages or Pension *(after deductions)*	$	$
Social Security/Disability Income	$	$
Alimony/Child Support	$	$
Public Assistance/Welfare/Food Stamps	$	$
Other *(please list)*:	$	$

Monthly Income Totals [1] *for office use only*	$	$

Monthly Payments

Property	*Value*	*Balance Due*	*Monthly Payment*
Residence: ☐ Rent ☐ Own	$	$	$
Property Payment Subtotal [2] *for office use only*	$	$	$

Vehicles	*Make/Model*	*Year*	*Value*	*Balance Due*	*Monthly Payment*
Vehicle #1			$	$	$
Vehicle #2			$	$	$
Vehicle Payment Subtotal [3] *for office use only*			$	$	$

Medical Expenses (if more lines needed attach on separate sheet)			
Hospital/Physician/Medical/Provider/ Pharmacy	*Amount Insurance will pay*	*Balance Due*	*Monthly Payment*
	$	$	$
	$	$	$
	$	$	$
Medical Payment Subtotal [4] *for office use only*	$	$	$

Charge cards/revolving credit/bank loans/furniture rentals (if more lines needed attach on separate sheet)			
Name of Creditor	*Purpose of Charge*	*Balance Due*	*Monthly Payment*
		$	$
		$	$
		$	$
Revolving Credit Subtotal [5] *for office use only*		$	$

Utilities					
	Monthly Payment		*Monthly Payment*		*Monthly Payment*
Heating Fuel	$	Electric	$	Water/Garbage	$
Phone	$	Cable TV	$		$
Other Monthly Expenses					
		Monthly Payment			*Monthly Payment*
Food		$	Auto Insurance (for 6 months)		$
Health Insurance (if not deducted automatically from paycheck)		$	Other *(please specify)*:		$
Utilities and Other Monthly Expenses [6] *for office use only*					$

****This Box is For Office Use Only****

Monthly Finance Statement

Total Income [1]		Other Required Payments [5]	
Rent/Housing [2]		Other Monthly Expenses [6]	
Vehicle Expenses [3]		Total Expenses [2+3+4+5+6 = 7]	
Monthly Medical Expenses [4]		Spendable Funds [1-7]	

Patient Conditions and Comments

Have you ever filed for bankruptcy? ☐ No ☐ Yes If yes, Year:______________

If yes, was DBH included? ☐ No ☐ Yes

How much can you pay each month for DBH treatment services? $________________

How much more can you pay each month towards your past account balance? $________________

Have you applied for Medicaid and been denied or found to be ineligible? ☐ Yes ☐ No

Please explain your answer:

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Have you asked for assistance from your family? ☐ Yes ☐ No

Please explain your answer:

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Have you asked for assistance from your clergy/church? ☐ Yes ☐ No

Please explain your answer:

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Any additional comments:

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Information written on this form is true and complete. I am giving added papers to prove the form information is current and accurate. I know that if the information I gave is not true or not complete I will not get help on my account and I will have to pay my whole balance. I know that filling out this form is not a promise from DBH of any help with my balance.

____

Print Name Signature Date

DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Davis Behavioral Health

HARDSHIP WAIVER PROVIDER RECOMMENDATION FORM

Date:

Client Name: Client #:

Provider Recommendation

Provider Name:____

Services provided to this client:____

How often is this client seen? ____

Do you plan on continuing treatment for this client? ☐ Yes ☐ No

In your opinion, was this client able to make a co-payment at the time of each prior visit? ☐ Yes ☐ No

Please state clinical reasons why you feel that this client needs special financial consideration:

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Recommended Adjustment for client’s fee per service: $__________/month or ________%

Recommended Adjustment for client’s prior balance: $__________ or ________%

I recognize that hardship waiver requests are an exception not to be taken lightly and that any amounts adjusted from this account as a result of the current application will be deducted from my program’s available treatment funds. The above statement of clinical reasons and my recommendation for adjustments proposed is my best professional judgment regarding this client.

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Provider *(print name)* Signature Date