

# Five County Mental Health Authority

NEW   
 UPDATE   
 REOPEN

## FINANCIAL DATA SHEET

MR# 
 Date of Birth 
 Sex  M / F  Soc Sec #   
(circle one)

Client Name

\_\_\_\_\_  
Last
First
MI

**Responsible Party Name/Address/Telephone** (Complete only if different from client)

\_\_\_\_\_  
Last
First

\_\_\_\_\_  
Street Address
City
State
Zip

\_\_\_\_\_  
Home Phone
Work Phone

**\*\*Payment is expected at the time of service.**

Household Income \_\_\_\_\_ Family Size \_\_\_\_\_ Employer: \_\_\_\_\_

SUBSIDIZED FEE SCHEDULE (Please circle one)										
NUMBER IN HOUSE HOLD	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
1	\$9,310	\$12,801	\$15,827	\$16,203	\$17,689	\$18,784	\$19,879	\$20,274	\$28,320	OVER
2	\$12,490	\$17,174	\$21,233	\$21,858	\$24,980	\$26,541	\$28,102	\$31,224	\$42,024	
3	\$15,670	\$21,546	\$26,639	\$27,423	\$31,340	\$33,299	\$35,258	\$39,174	\$52,728	
4	\$18,850	\$25,919	\$32,045	\$32,988	\$37,700	\$40,056	\$42,412	\$47,124	\$63,433	
5	\$22,030	\$30,291	\$37,451	\$38,553	\$44,060	\$46,814	\$49,568	\$55,074	\$74,136	
6	\$25,210	\$34,664	\$42,857	\$44,118	\$50,420	\$53,571	\$56,722	\$63,024	\$84,840	
7	\$28,390	\$39,036	\$48,263	\$49,683	\$56,780	\$60,329	\$63,878	\$70,974	\$95,544	
OVER 7	\$31,570	\$43,409	\$53,669	\$55,248	\$63,140	\$67,086	\$71,032	\$78,924	\$106,248	

**\*\*\*Attach copy of income verification, medicaid Card, and BOTH sides of Insurance Card\*\*\***

**Insurance Information**

Primary Insurance	Effective Date	Policy Holder	Relationship	Unicare Insurance code
Secondary Insurance	Effective Date	Policy Holder	Relationship	Unicare Insurance code

I certify that the information I have provided on this form is complete and accurate to the best of my knowledge. I agree to the filing of any and all third party insurance coverage and payment of such claims to be remitted directly to VGFW. I have received a copy of the **FEE INFORMATION** handout and understand my payment obligations. I understand that my payments are due at time of service and that taking responsibility for this obligation is part of my treatment. This form can be updated whenever there is a change in financial status.

\_\_\_\_\_  
Client/Responsible Party Signature
Date
Provider #