COPAY: ____

WESTBROOK HEALTH SERVICES, INC. FINANCIAL DATA SHEET

☐ **Update** ☐ **Fee Waiver (Charity Care)** ☐ **Intake – Clinician:** _____		
Date:	**Client ID:**	
Last Name:	**First Name:**	**Middle Name:**

Client
Date of Birth _____/_____/_____
Social Security Number _____-_____-_____
Gender ☐ Male ☐ Female
☐ Identify as: _____
☐ Prefer not to disclose
Race _____
Marital Status _____
If client is a minor, or is not their own guardian, please also fill out the information on the right.

Guardian Name_____
Relationship to client: _____
Date of Birth _____/_____/_____
Social Security Number _____-_____-_____
Address (if different):
_____
City _____ **State** _____ **Zip** _____

Home Address:
_____
City: _____ State: _____
County: _____ Zip Code: _____
Months at this address: _____
May we send you mail? ☐ Yes ☐ No

Mailing Address (if different):
_____
City: _____ State: _____
County: _____ Zip Code: _____
E-mail address: _____
May we e-mail you? ☐ **Yes** ☐ **No**

Telephone Number: **Can we leave a voicemail?** **What is your contact preference?**
Home: (_____)-_____-_____ ☐ Yes ☐ No ☐ **Call** ☐ **E-mail** ☐ **Text**
Cell: (_____)-_____-_____ ☐ Yes ☐ No
Other: (_____)-_____-_____ ☐ Yes ☐ No
By checking these boxes, I consent to have service notifications, appointment reminders, and other notifications provided to me. I understand I have the right to revoke this consent, in writing at any time, and the revocation will be effective except to the extent that Westbrook Health Services or its staff has already taken action in reliance to my consent.
☐ Please check this box if you would **NOT** like to be called or receive text reminders at any phone number listed.

Family Doctor/Primary Care Physician:
Name: _____
Phone: **(_____)-_____-_____**

Emergency Contact Information:
Name _____
Relationship: _____
Phone: (_____)-_____-_____

Family Finance
Total number of IRS-defined dependents in household: ____
☒Self/Client How many: __1__
☐Spouse/Guardian How many: _____
☐Dependents under 18 How many:_____
☐Dependents over 18 How many:_____

Family Monthly Income
Amount $_____ Type _____
Amount $_____ Type _____
Amount $_____ Type _____
☐I am **not** interested in the Fee Waiver (Charity Care) and I prefer not to disclose my income.

WESTBROOK HEALTH SERVICES, INC. FINANCIAL DATA SHEET

Is this individual court-ordered or recommended by their attorney into treatment? ☐ Yes ☐ No
Were copies of available information regarding co-pay, co-insurance, and deductible provided? ☐ Yes ☐ No
Would you be interested in getting information about Westbrook's Primary Care Program? ☐ Yes ☐ No

Agreement and Understanding

1. FINANCIAL AGREEMENT: I CERTIFY THAT ALL OF THE INFORMATION CONTAINED IN THIS DOCUMENT IS CORRECT. I FURTHER CERTIFY THAT, IF PERTINENT OR MAY BECOME PERTINENT TO ME, I HAVE READ THE CHARITY CARE PORTION OF THIS DOCUMENT AND AGREE TO FOLLOW THESE REQUIREMENTS DURING THE DESIGNATED TIME OF TREATMENT. IF I DO NOT COMPLY WITH THE ABOVE REQUIREMENTS, I UNDERSTAND THAT I WILL NOT BE ELIGIBILE AND WILL NOT RECEIVE CHARITY CARE SERVICES.

2. HANDOUT: I CERTIFY THAT I HAVE BEEN OFFERED A COPY OF THE FINANCIAL/CHARITY CARE HANDOUT AND UNDERSTAND THAT I MAY ASK FOR A COPY AT ANY TIME IF I CHOSE NOT TO TAKE A COPY TODAY.

3. PHOTOGRAPH: I CONSENT TO ALLOWING WESTBROOK TO TAKE MY PICTURE FOR INCLUSION IN MY MEDICAL RECORD:
☐ Yes ☐ No

4. I HAVE READ THESE AND HAVE BEEN PROVIDED AMPLE TIME TO ASK HAVE MY QUESTIONS FULLY ANSWERED. I HAVE SIGNED INDICATING MY UNDERSTANDING OF THE TERMS OF THIS FINANCIAL AGREEMENT AND FINANCIAL/CHARITY CARE HAND OUT, WHICH INCLUDES REFERENCES TO PAYMENT PLANS FOR UNPAID BALANCES PROCEDURES. I AGREE TO ABIDE BY ALL OF THEM.

_____ _____

Consumer Signature Date Guardian/Legal Representative Signature Date

_____ Are you this individual's legal guardian? ☐ Yes ☐ No

Staff Signature Date

WESTBROOK HEALTH SERVICES, INC. FINANCIAL DATA SHEET

INSURANCES (Staff Only)

MEDICAID

Medicaid Number/Eligibility ID: _____ Effective Date: _____

☐Categorically Needy – Traditional Medicaid

☐HBPE, Hospital Presumptive Eligibility – Traditional Medicaid

☐Alternative Benefit Plan (ACA) APB – Traditional Medicaid

☐BMS state programs – Special Billing Letter

☐Qualified Medicare Beneficiaries – QMB

☐Behavioral Health and Health Facilities - BHHF

☐Title XIX I/DD Waiver (no balance billing allowed)

☐Title XIX TBI Waiver (no balance billing allowed)

☐SUD Waiver – Residential Services & Peer Support

Medicaid Managed Care Organization

☐Unicare Medicaid MCO

☐WV Family Health / Beacon Medicaid MCO

☐Aetna Medicaid MCO

☐HealthPlan Medicaid MCO

MEDICARE

Medicare Number/Eligibility ID: _____ Effective Date: _____

Does this individual have a Medicare Advantage plan card? ☐Y ☐ N

Name of Medicare Advantage Program: _____

THIRD-PARTY INSURANCE

Were copies of identification cards and Insurance Verification/Pre-Certification forms attached? ☐Y ☐ N

Insurance Name: _____ Group Number: _____ Policy Number: _____

Insurance Name: _____ Group Number: _____ Policy Number: _____

OTHER

☐Responsible Party/Private Pay (see front page for responsible party details)

☐Court _____ Address: _____ Contact: _____

☐Self-pay ☐ Self-pay Agreement

☐Other: _____

FEE WAIVER (CHARITY CARE)

WV Resident Status: ☐Y ☐ N

Examples: WV DL/ID card copy, WV Application copy,
Utility bill w/ WV physical address (PO Box unacceptable except WV DL)

Financial: ☐Y ☐ CRISIS ☐N **SEE FIRST PAGE FOR BREAKDOWN OF INCOME**

1. Individual and Family Income (per Federal Poverty Level) - Below Poverty (proofs of income – 1-6) OR
2. Standard Justification (no documentation) signed by client

Service:

☐Y ☐ CRISIS ☐N

Consumer's BHHF Client Eligibility (APS validation from CareConnection) will serve as documentation.

Effective Dates: _____-_____

BHHF Eligibility may be determined by the consumer: being at or below 200% poverty level; not being covered by third party; not participating in Target Funding Service Program; medical / clinical necessity being documented in the record; being diagnosis-eligible under Medicaid clinic, Rehab, CM; having a history of hospitalization for MH, SA or DD; living in a controlled setting such as a group home; receiving supportive residential services; receiving services under WV code chapter 27; receiving crisis services