| OFFICE USE ONLY | |
|---|---|
| **Applicant ID #:** | |
| Date Received: | |
| Date Processed: | |

HILLTOP CARES FOUNDATION

# Applicant Medical Cost Report – CONFIDENTIAL

| DATE |
|---|
| |

| MEDICAL PROVIDER | | | RETURN TO |
|---|---|---|---|
| ADDRESS | | | |
| CITY | STATE | ZIP CODE | |

| NAME OF APPLICANT | DATE OF BIRTH |
|---|---|
| | |

**I hereby authorize my medical provider to release my medical history information including information on the topics I have initialed below. This information is required as part of an application for benefits in order to verify the costs of mental health treatment. This release of information is valid for one year after the date of my signature.**

**_____ therapy, _____ mental health medication.**

SIGNATURE OF APPLICANT _____ DATE _____

| DATE FIRST SEEN BY PROVIDER | DATE OF LAST MEETING WITH PROVIDER |
|---|---|
| FREQUENCY OF MEETINGS WITH PROVIDER | COST<br>**$** **Monthly / Weekly** (Please circle one) |

CURRENT MEDICATIONS

| MEDICATION NAME | PURPOSE OF MEDICATION | MONTHLY COST |
|---|---|---|
| | | **$** |
| | | **$** |
| | | **$** |
| | | **$** |

COMMENTS

| MEDICAL PROVIDER'S SIGNATURE | DATE |
|---|---|
| | |

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