Human Services Inc.

Application for County Liability Funding

County Liability funding is available for those that currently do not have insurance, or do not have coverage by their insurance for a specific program. It cannot be used to cover copays or certain court ordered programs. We use your household income, number of dependents and other financial factors to determine your monthly liability payment. The fee schedule is set by the county. The monthly fee covers the specific programs you are enrolled for with Human Services, Inc. Payment is due at the beginning of the month when you have your first service. If you do not make your monthly payment, you will not be scheduled for any services the following month until you have made your payment. If you are applying due to lack of insurance, you are required to apply for Medicaid. If you are denied, or have recently been denied, please provide us with a copy of the letter. If you are approved for Medicaid, you must notify us immediately as to not cause billing delays.

As a County Contracted Organization, we are **required** by Chester County to obtain financial and demographic information for all those using this program. **Failure to provide this information could result in being charged full fee or refusal of services.** This will occur at least annually, and with all insurance, employment or benefit changes you may experience. Please provide the following and complete the attached form:

- Photo ID
- Financial Information
  - 3 Consecutive current paystubs (for you and spouse if in same household)
  - Benefit letters from Social Security, Unemployment, Welfare
  - Complete bank statements from the past 2 months
- If you have no income, we need a statement from the person who supports you financially
- Expense Information
  - Medical Expenses (PAID bills only from the past 12 months)
  - Out of pocket payments for medications (report from pharmacy/receipts past 12 months)
  - Verification of child care expenses
  - Real estate tax information (if member of household owns the home)

If there is a change in any of the above information, you will need to update your liability within 10 days of the change. If you obtain new insurance, you must notify us IMMEDIATELY. Failure to do so my result in the inability for us to bill properly and you will be liable for any outstanding balance.

Please contact the billing department at 610-873-1010 ext 174 with any questions.

Info can be submitted by mail: HSI /Fiscal Dept 50 James Buchanan Dr Thorndale, Pa 19372

Email : Intake@HSI-CMHS.org or Fax 610-873-9307

Name _____Date_____

Address_____

Own / Rent /Other_____ Mode of transportation: Own car / Bus / Friend or family

Are you employed? FT / PT Where _____ Collecting Benefits? SSI / SSDI /UC

If no source of Income, who is providing support for you (shelter, clothes, food) _____

Must provide written proof from source , signed and dated

Are you a veteran or active military? Yes or No Highest level of school completed _____

Are you of Hispanic Origin? _____ Race _____

Marital Status - Single Divorced Widow Separated Married -spouse name _____

Does your spouse have income? Yes or No , if yes, please provide paystubs or benefit letter

Do you have any dependents? (do you claim anyone on your taxes) Yes No

Please List all dependents including DOB. If more space is needed, please write on back of form

Name_____DOB_____relation_____

Name_____DOB_____relation_____

Name_____DOB_____relation_____

Name_____DOB_____relation_____

Do you have Childcare expenses? No Yes – please provide proof of payments

Do you have any paid medical expenses for the past 12 months (prescription cost,copays) ?

No Yes -please provide receipts

If you own home, have you paid your real-estate taxes? Provide statements of payment

By submitting this information, you are attesting that your statements are true and correct and you agree to terms and conditions of using this coverage.

Signature of applicant_____