# ANDREWS CENTER
# COMMUNITY SERVICES FINANCIAL STATEMENT

******* CONSUMER INFORMATION *******

Consumer Name:
Street Address:
Mailing Address:
City, State, Zip:
Date of Birth:

Local Case #:
Telephone #:
Social Security #:
Marital Status:

Sex: Male ☐ Female ☐

Is the consumer:

☐ Minor
☐ Minor under guardianship/CPS:
Name of legal guardian

☐ Legal Adult
☐ Adult under guardianship/APS:
Name of legal guardian

Responsible party IF different from the consumer:
Parent's Name:
Mailing Address:
City, State, Zip:
Home Phone #:
Work Phone #:

Did consumer bring (Attach copies of verification provided by consumer):
☐ Proof of Income, Describe below
☐ Proof of Residency, Describe below
☐ Proof of Insurance, Describe below

***** CONSUMER'S MEDICAID AND/OR MEDICARE INFORMATION (Attach copy of Card) *****

**MEDICAID:**
Medicaid Recipient (ID) #:
Eligibility Effective Date:

* QMB Y ☐ N ☐
If yes, please be sure to load #800 QMB Medicaid
Otherwise, #1041 will need to be loaded.

* Does not pay for Rehab and Service Coordinator services!

**MEDICARE:**
Medicare Recipient (ID) #:

* Part A (Hosp. Ins.) Eff. Date:
Part B (Med. Ins.) Eff. Date:

* Note: Only Medicare Part B pays for our services

******* CONSUMER'S THIRD PARTY INSURANCE (Attach copy of Card and Lifetime Assignment of Benefits) *******

☐ **Third Party/Private Insurance** ☐ **CHIP** ☐ **Champus/Tricare**

Policy Holder's Name:
Relation to Consumer:
☐ Self
☐ Spouse
☐ Parent
☐ Other: Describe

Insurance Company:
Address:
Address:
City, State, Zip:
Insurance Co. Phone #:

Policyholders SS#:
Policyholders Phone
Employer Name:
Eff. Date of Policy:
ID or Policy #:
Group #:

☐ Y ☐ N Is there an additional insurance coverage?
☐ Y ☐ N If yes, is a copy of the additional insurance card attached?
Name of the additional Insurance Company

******* OTHER FUNDING SOURCES *******

☐ Van Zandt Juvenile Justice System (must be entered as Guarantor)
Effective Date

☐ Texas Rehab Commission (must be entered as Guarantor)
Effective Date

☐ OTHER Effective Date:
Describe:

Consumer has no insurance benefits and is requesting TDMHMR financial assistance. This requires application to Medicaid / CHIP. Referral to Andrews Center Benefits Dept made on (Date) by (Staff Name)

**PLEASE FORWARD A COPY OF THESE PAGES WITH COPIES OF INSURANCE CARD(S), PROOF DOCUMENTS, AND LIFETIME ASSIGNMENT OF BENEFITS TO THE FRONT DESK SECRETARIES. THANKS.**

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**INCOME:**

ELIGIBLE FAMILY MEMBER'S INCOME PER STATE IF CONSUMER IS:

| ADULT | CHILD |
|---|---|
| Self | Biological / Adoptive Mother living in household |
| Spouse in the household | Biological / Adoptive Father living in household |
| | Child (if the child is the consumer) |

NOTE: Child support payments and food stamps ARE NOT applicable income. Income for minors, OTHER THAN WAGES, IS applicable income IF the consumer is the minor.

***** FAMILY GROSS MONTHLY INCOME *****

| | Name / Relationship: List MONTHLY income Below for this family member | Name / Relationship: List MONTHLY income Below for this family member | Name / Relationship: List MONTHLY income below for this family member |
|---|---|---|---|
| Social Security Benefits (SSDI): | $ | $ | $ |
| Supplemental Security Income (SSI): | $ | $ | $ |
| Veteran's Benefits: | $ | $ | $ |
| Railroad Benefits: | $ | $ | $ |
| Wages (List Co. Name): | $ | $ | $ |
| TANF (old AFDC): | $ | $ | $ |
| Misc. Other Income: | $ | $ | $ |

**(A) SUB-TOTAL ALL MONTHLY INCOME(S): $**

**DOCUMENTED EXTRAORDINARY EXPENSES, IF APPLICABLE:**
(Add all extraordinary expenses PAID during the past 12 months OR projected for the next 12 months.)

| | | |
|---|---|---|
| Major Medical or Health Related (Pd. Monthly): | $ | Vendor: |
| Major Casualty Losses (Pd. Monthly): | $ | Vendor: |
| Child Care (Pd. Monthly): | $ | Vendor: |

Do **not** include child support

**(B) SUB-TOTAL ALL MONTHLY EXTRAORDINARY EXPENSES: $**

Monthly Income **(A)** x 12 months: $
(minus) Extraordinary Expenses **(B)** x 12 months: $ -
**>>>Total Eligible Annual Income:** $

**FAMILY SIZE:**
ELIGIBLE FAMILY MEMBERS PER STATE IF CONSUMER IS:

| ADULT | CHILD |
|---|---|
| ☐ Self | ☐ Self |
| ☐ Spouse in the household, Name | ☐ Biological / Adoptive Mother living in household, Name |
| ☐ Biological / Adoptive minor children in household, Name(s): | ☐ Biological / Adoptive Father living in household, Name |
| | ☐ Biological/adopted minor siblings in household, Name(s): |

**TOTAL ELIGIBLE FAMILY MEMBERS LISTED ABOVE:** **TOTAL ELIGIBLE FAMILY MEMBERS RECEIVING SERVICES:**

**FEE DETERMINATION FOR STATE FUNDED SERVICES:**

Maximum Monthly Fee:
Fee Determined By:
Date
Will MMF be split between other members? If yes, Clt #
Consumer / Family/ Payee Informed of Rate? Y ☐ N ☐

Suppress Mailing of Statement (Statement suppression no more than 90 days) ? Y ☐ N ☐
If Yes, Explain

Patient Accounting Review: Agree ☐ Disagree (Patient notified in writing) ☐ Initial suppression date

I understand that my insurance will be billed for services provided. I request payment for service be made directly to Andrews Center. I understand the information released to the insurance company may include my diagnosis (mental health, mental retardation, substance use/abuse, HIV, and AIDS) as they relate to the type and scope of services provided. The information on this financial statement is true and correct to the best of my knowledge. I will inform Andrews Center of any changes in my income or household. I have received a copy of the Fee Schedule and the informational brochure.

☐ I choose not to provide financial information. I agree to pay 100% of charges incurred.

Signature of Consumer: _____ Date: _____

Signature of Parent of Minor or Legal Guardian: Date: