

YOUTH DYNAMICS
FINANCIAL INFORMATION SHEET

Client Name: _____ SSN: _____

Client Date of Birth: _____

Legal Guardian: _____ Funding Agency (If applicable):

Please Circle: CFS BIA DOC Youth Probation KMA

Other (Family Member, Tribe, IVE): _____ or Request for Scholarship: _____

Service(s) Requested (Please Circle): TFC Int Group Care Mod Group Care Shelter Care FST
Guide Home FSA Respite YCM Therapy – Assessment–Indiv-Family-Group Supr Visitation
PIP Other: _____

Medicaid Eligible: Yes No

Medicaid Number: _____

Please attach copy of Medicaid Card

Private Insurance: Yes No *(If no, please skip to the next section of this form)*

Subscriber Name: _____ Subscriber SSN: _____

Subscriber Date of Birth: _____

Home Address of Subscriber: _____

Home Phone Number: () _____ Street / P.O. Box _____ Employer: _____ City _____ State _____ Zip _____

Insurance Company: _____ Phone Number: () _____

Address: _____

Policy Number: _____ Group Number: _____

Please attach copy of Insurance Card(s) (front and back)

Sliding Fee Schedule – Service Agreement (Review and Sign Form FIN31B(D))

Parent/Guardian Name: _____ SSN: _____

Spouse's Name: _____ SSN: _____

Home Address _____

Home Phone Number: () _____ Street / P.O. Box _____ Cell Phone: _____ City _____ State _____ Zip _____

Employer: _____ Employer Phone Number: () _____

Employer Address: _____

Spouse's Employer: _____ Employer Phone Number: _____

Employer Address: _____

Additional Sources of Income (Include any subsidies or SSI) _____

For Private Insurance (to satisfy deductibles and co-pays) or for Private Pay (Service Agreements, please attach a copy of the most recent Federal Tax Return and copies of two most recent paystubs, along with verification of any additional source of income. Complete and sign the Sliding Fee Schedule Agreement and forward to the Finance Department.

Services will not be rendered until funding is approved by the Finance Director of YDI

I hereby authorize Youth Dynamics to contact my insurance company to verify benefits and deductibles, and payments on services provided to be paid directly to Youth Dynamics. ***A photocopy or a fax copy of this form is valid as original.*** I understand that billing information may include chart notes specific to treatment as requested by my insurance company in order to process and collect payment. I also understand that I am financially responsible for services if eligibility or authorization lapses.

Authorized Signature: _____ Date: _____