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: (____) _____ Employer: _____
Street / P.O. Box 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: (____) _____ Cell Phone: _____
Street / P.O. Box 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: _____