Financial Information Form

Annual household income: ____________________

Number of persons supported by income: ___

Dependents under the age of 18: ___

Social Security (SS): Y/N

Social Security Disability Insurance: Y/N

DETERMINES IF:

Financial Assistance: Not Eligible

On behalf of MHCD, I have reviewed this individual's financial situation as reported by the individual. Based on the individual's best guess of the yearly household income and number of persons supported by that income, the individual's household income is above 330% of the current federal poverty guidelines. Therefore, this individual does not qualify for MHCD's Financial Assistance Program.

OR

Financial Assistance: Eligible

On behalf of MHCD, I have reviewed this individual's financial situation as reported by the individual. Based on the individual's best guess of the yearly household income and number of persons supported by that income, the individual's household income is at or below 330% of the current federal poverty guidelines. Therefore, this individual qualifies for MHCD's Financial Assistance Program.

By signing below, I confirm, to the best of my knowledge and belief, my household income and the number of persons supported by that income, as shown above. I understand that MHCD is using this information to determine whether I am eligible to have my financial responsibility, except medication co-payments, waived through MHCD's Financial Assistance Program. I agree to notify MHCD if my financial situation changes or I learn something about my financial situation different than what I reported. I understand that at least once a year MHCD will ask me to verify my information.

Signature:

Date: