



Client ID \_\_\_\_\_

**Recovery Groups Uninsured/Non-Covered Assistance Program  
(Court Ordered Groups Only-court order copy required)**

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ SS#: \_\_\_\_\_

County of Residence: \_\_\_\_\_ (Eligible counties – Cass, Miami, Fulton and Pulaski)

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Client if different from Applicant: \_\_\_\_\_

Have you or any household member applied for Medicaid, Medicare, Disability, Social Security or any other Federally Funded Program? Yes / No If so, please list: \_\_\_\_\_ Date of recent application: \_\_\_\_\_

Name	Insurance Coverage Name	Policy Number

I (applicant) understand that I must pay my discounted fee of \$25 at the time of service in order to continue on the Assistance Program. *(please initial)* \_\_\_\_\_

I (applicant) understand that I must provide a copy of my court order from one of the above listed counties in order to qualify for the Assistance Program. *(please initial)* \_\_\_\_\_

I (applicant) understand that this assistance applies only to Recovery (substance abuse) group services only and that I am expected to pay for all other services accordingly. *(please initial)* \_\_\_\_\_

I (applicant) understand that I must renew this application every 6 months. *(please initial)* \_\_\_\_\_



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I (applicant) understand that providing false information will result in termination of services and 4C Health may refer documents to an appropriate federal agency for further investigation. *(please initial)* \_\_\_\_

Please attach copies of the following documents:

Valid Photo ID

Court Order

Verification of address and county of residence

Presumptive Eligibility approval/denial letter

Signature of Patient/ Head of Household/Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of 4C Health Agent: \_\_\_\_\_

Date: \_\_\_\_\_

Document Verification – FOR OFFICE USE ONLY
Identification/Photo ID
Copy of court order
Verification of address and county of residence
Presumptive Eligibility approval/denial letter
Approved or Denied (circle one)
Date entered in Avatar:
Date letter sent to client:
Staff signature: