**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) \_\_\_\_\_\_\_\_\_\_\_***

**I (applicant) understand that providing false information will result in termination of services and Four County 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 Four County Counseling Center 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:  |
|  |