ANA·ZAO
COMMUNITY PARTNERS

Financial Agreements

Financial Agreements:

Initial below indicating you have read and understand the following statement.

_____ I authorize enrollment in the Mental Health and Recovery Board (MHRB) plan and PartnerSolutions Health Informatics Consortium (PSHIC). I request that ACP bill any eligible charges under that plan, and authorize payment of benefits to ACP for services provided. I understand that ACP uses a scale based on the size and income of my household to determine fees. I understand that I may be responsible for payment for services denied by my insurance or Medicaid/Managed Care Organization (MCO) plan. I understand that I must provide proof of income (current pay stub, recent tax form, statement from employer) to determine eligibility for some funding. I understand that if my family has no income, I must attest to this. I understand that I must provide ACP with proof of any change of income. I understand that not providing proof of income may result in my being charged the full hourly fee (up to $131 per hour) until this is provided. I understand that once my fee has been calculated, this will be provided to me. I understand that payment is due at the time of service. I understand that delinquent accounts may be turned over to a collection agency. This information is also available for me to review at www.anazao.co.

Income Statement

Name of individuals in home:	Age:	Relationship to client:

List all income for household members: *Enter Either Weekly or Monthly, not Both*

Income Type:		Per Hour:	$	Per Month:	$
		Hrs Per Week:			
Income Type:		Per Hour:	$	Per Month:	$
		Hrs Per Week:			
Income Type:		Per Hour:	$	Per Month:	$
		Hrs Per Week:			
Income Type:		Per Hour:	$	Per Month:	$
		Hrs Per Week:			

Insurance and/or Medicaid Information

Name of Insurance Company or Medicaid Managed Care Organization*	Policy-Holder Name	Policy-Holder Relationship to Client	County of Public Assistance
Policy or ID Number	Group or Case Number	*Presumptive Medicaid, Aetna, Buckeye, CareSource, Molina, Paramount, United, or Other (Write-in)	
Address or 800 # for Claims			

I authorize payment of services provided by ACP to be paid directly to ACP. I authorize ACP to release any information regarding claims for services to my insurance carrier/managed care organization.

Client (adult) or Guardian: _____ Date: _____

Policy-Holder: *if different from Guardian* _____ Date: _____

Witness: _____ Date: _____

REVISION 8.22.18

For questions about this form, or assistance completing the form, please call our office at 1-800-721-9472.