Family Service of Rhode Island

FINANCIAL ASSISTANCE APPLICATION

Please return completed application and supporting documents to:

Family Service of Rhode Island, Inc.
PO Box 6688
Providence, RI 02940-6688

Business hours: 8 a.m. – 4:30 p.m.
Business days: Monday - Friday
Phone number: 401-277-3362
Email: AR@familyserviceri.org

Financial Assistance Application
Including List of Required Supporting Documents

It is the policy of Family Service of Rhode Island (FSRI) to ensure all individuals and families have access to care and are not denied a service under FSRI's Certified Community Behavioral Health Clinic (CCBHC) based on their ability to pay, including our Designated Collaborating Organizations (DCO) services.

To be considered, please complete this application to help FSRI determine whether you may qualify to receive financial assistance or our sliding fee discount. Even if you apply, we cannot guarantee that you will qualify. A written response will be provided to all clients supporting approval/denial after we receive your completed application and documentation.

You may submit the completed, signed and dated application by mail or email.

- A completed application must include the date and signature of the applicant.
- There are no required deadlines for applying.
- In addition to the application, provide proof of income documentation for both you and your spouse/partner (if married, in a civil union, or domestic partnership). This documentation will be either **pay stubs** (the two most recent) or **federal tax return** (prior year).
- Missing or unattached documents may cause a delay or denial of financial assistance.
- Please see our Financial Assistance Policy for additional details.

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Client Information

Client name	Social Security number	Date of birth	
Home address	City	State	ZIP code
Home phone number / Cell phone number	Email address		

Preferred method of contact
☐ U.S. Mail ☐ Email ☐ Home phone ☐ Cell phone

Annual household income:
$_____

Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Number of individuals in your household (as reported on your taxes):

Employment status:
☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled
☐ Unemployed – Last date worked: _____

Employer name	Phone number		
Employer address	City	State	ZIP code

Spouse/Domestic Partner/Parent/Guarantor Information

Relationship to Client
☐ Spouse ☐ Domestic partner ☐ Parent ☐ Guarantor ☐ Other: _____

Name	Social Security number	Date of birth

Employment status:
☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled
☐ Unemployed – Last date worked: _____

Employer name	Phone number		
Employer address	City	State	ZIP code

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Insurance Coverage

Are you eligible for any health insurance coverage? ☐ **Yes** ☐ **No**
If "Yes," please provide following:

Policy holder	Insurer	Policy number
Policy holder	Insurer	Policy number

Income & Expense Information

Monthly Income (Current)	**Client/Guarantor**	**Spouse/Partner**	**Total**
Gross income	$	$	$
Monthly Essential Living Expenses	**Client/Guarantor**	**Spouse/Partner**	**Total**
Rent or mortgage	$	$	$
Real estate taxes	$	$	$
Home maintenance, cleaning and household supplies	$	$	$
Utilities and telephone	$	$	$
Clothing and laundry	$	$	$
Medical and dental	$	$	$
Alimony/Child support	$	$	$
Transportation and auto (insurance, gas, repairs, lease)	$	$	$
Education	$	$	$
School/Childcare (minor dependents)	$	$	$
Food	$	$	$
Insurance	$	$	$
Other extraordinary expenses	$	$	$
Total monthly expenses	$	$	$
Medical Debt (Current)	**Client/Guarantor**	**Spouse/Partner**	**Total**
Outstanding medical debt	$	$	$
Other medical debt	$	$	$

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I certify that the information in this application is true and correct to the best of my knowledge. I agree to apply for any local, state, and federal assistance for which I may be eligible, to help alleviate the cost of any professional service bills. I understand that the information provided may be verified by the Agency and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provided incorrect information or if the application contains a material error or omission, I will no longer be eligible for financial assistance. If financial assistance was previously granted to me, it may be reversed at that time, and I will be held responsible for the outstanding balance.

Signature of person applying for financial assistance _____ Date _____

Signature of spouse/domestic partner/guarantor (if applicable) _____ Date _____