Cohen Compensated Care Fund (CCC Fund)
Request for Assistance

The Steven A. Cohen Military Family Clinic at (clinic's name) works in affiliation with Cohen Veterans Network, Inc. (CVN) [a 501(c)(3) nonprofit organization] to help fill gaps in mental health care for post-9/11 veterans, service members, and family members. While the clinic is supported by CVN's philanthropy, funding is not unlimited and we are committed to the sustainability of our model. As such, **The Steven A. Cohen Military Family Clinic at (clinic's name)** will bill a client's insurance and collect co-payments as appropriate to help extend the reach of the Cohen Clinic to ensure we can continue to provide services to veterans, service members, and their family members in the future. Should you/your family encounter financial hardships, we will work with you to make sure that the ability to pay is not a barrier to receiving the care you or your family need.

If you feel that you may not be able to afford the total cost of care, co-payment, co-insurance and/or deductible; please complete this section to determine eligibility for Cohen Compensated Care funding:

Client Legal Name: _____ Client DOB: _____

Responsible Party Name (if different): _____

_____ I am not requesting assistance at this time.

Reason for Request:

____I have insurance and feel I cannot afford any co-payment, co-insurance, or deductible amounts, and as such request to be considered as a recipient of the Cohen Compensated Care Fund.

____I have insurance and elect not to allow The Steven A. Cohen Military Family Clinic at (clinic's name) to bill on my behalf. As such I request to be considered as a recipient of the Cohen Compensated Care Fund.

____I do not have insurance and as such understand that I qualify as a recipient of the Cohen Compensated Care Fund.

Note: The completion of this form applies to one episode of care and any related booster sessions; a new form should be completed for subsequent episodes of care.

Financial Attestation:

_____ Number of people in client's household

$_____ Annual household income

Annual Household Income:
(Note: Income includes, but is not limited to: salaries, pensions, unemployment payments, child support payments, interest income, dividends, rental income, social security, disability, or other financial assistance program income.)

____ Less than $25,000/individual or $50,000/family

____ Between $25,000-$50,000/individual or $50,000-$100,000/family

____ More than $50,000/individual or $100,000/family

Other:

Please use the space below to provide us with any other client/household personal or financial information or special circumstances that you would like to be considered as part of this assistance application:

ACKNOWLEDGEMENT

FRAUD WARNING:

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other persons, files a statement of claim containing false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

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I certify that all information provided in this application is true and correct.

Client's or Responsible Party Signature: Date:

_____ _____

CLINIC USE ONLY

Application reviewed by: _____

☐ N/A

☐ Client Approved as Recipient of Cohen Compensated Care Fund

☐ Application Denied

Reason:

_____

_____

_____

Terms of Assistance:

☐ CCC Fund will cover Co-payment, Co-insurance, and/or Deductible only
☐ CCC Fund will cover the total cost of care
☐ N/A

Funding will remain in effect for the duration of this Episode of Care (EOC) and any related booster sessions. Should the client need additional services under a new EOC, another Request for Assistance application must be submitted and considered for approval.

Reviewer Signature: Date:

_____ _____