Intervention Fundamentals

IF Financial Assistance Application Information

Intervention Fundamentals (IF) offers financial assistance for care provided by Qualified Healthcare Professionals licensed or certified as behavior analysts to eligible individuals and families. Based on your financial need, either reduced payments or free care may be available.

You may be eligible for financial assistance if you:

- have limited or no health insurance
- can show you have financial need
- provide IF with necessary information about your household finances

About the Application Process

To apply for IF Financial Assistance, please follow these steps:

- Fill out the IF Financial Assistance Application form in this packet.
  - > Include the supporting documents listed in the checklist.
  - > Note that you must first explore whether you are eligible for some type of insurance benefits that would cover your care.
  - > We then look at your income and family size to determine the level of assistance available to you. We use a sliding scale, based on federal poverty guidelines.
- We will get in touch with you to let you know if you are eligible for IF Financial Assistance.
- We can help you set up a payment plan for any remaining charges or bills that are not covered by IF Financial Assistance.

Please mail your completed application form and copies of your proof of income materials to:

IF Financial Assistance Fund
The New Sun Rising
PO BOX 58005
Millvale, PA 15209

If you have any questions, please contact The New Sun Rising at 412-983-1993

IF Financial Assistance Application Documentation Checklist

Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals, as IF can't return any documents sent with the application. If any of the documents are missing, it will delay the processing of your application.

If You Have Income or Assets such as:

- Wages, salaries, tips
- Business Income
- Social security income
- Pension or retirements income
- Dividends and interest
- Rent and royalties
- Unemployment compensation
- Workers' compensation income
- Alimony and child support
- Legal judgments
- Cash, bank accounts, and money market accounts
- Matured certificates of deposit, mutual funds, bonds, or other easily covetable investments that can be cashed without penalty

Attach proof of your household income, which may include:

- Social Security 1099 forms or award letters
- Unemployment or workers' compensation award letters
- Pay stubs for the last 3 months
- Most recent IRS Form 1040 and appropriate schedules
- If you are self-employed, you must include a full tax return with Schedule C and/or profit and loss statement
- Bank statements, mutual fund statements, money market accounts, COD's, Bonds, etc. (statements from the last 3 months)
- Support letters
- Other income, such as trust funds, charitable foundations, etc. (statements from the last 3 months)

If You Have No Income:

If you have no income, send us a letter of support. The person who provides your support must sign the letter.

Clinical Documentation:

- Treatment Plan designed by a qualified healthcare professional licensed or certified as a behavior analyst that targets a specific goal within the scope of toilet training, feeding, communication or sleeping.
- Documentation of the professional's certification(s)
- Itemized estimate for the cost of treatment to reach the goal

Your Completed and Signed Financial Assistance Application Form

Please complete all the parts of the form that apply to you. Note that a separate application must be completed for each individual patient who is requesting financial assistance.

IF Financial Assistance Application Application Form

Name of Applicant:	
Patient's Name:	Patient's Date of Birth:

Address:		
City:		State:
ZIP:	County:	

Daytime Phone Number:
Alternate Phone Number:

Employer's Name:	Spouse's Employer's Name:

Requested Services

Please check the skill/s for which you are requesting financial assistance

☐ Toilet Training ☐ Feeding Training ☐ Communication Training ☐ Sleep Training

Name of Service Provider

☐ Intervention Fundamentals ☐ Other:____________________________________

Household Information: List ALL members of your household, including dependents, who were on your most recent IRS Form 1040.

Names	Relation to Patient	Age

Total number of household members (including the patient): ______________________________

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your proof of income documents (see documentation checklist).

Monthly Gross Income	Self	Spouse and/or Other Household Members
Wages/self-employment	$	$
Social Security	$	$
Pension or retirement income	$	$
Dividends and interest	$	$
Rents and royalties	$	$
Unemployment	$	$
Workers' compensation	$	$
Alimony and child support	$	$
Cash	$	$
Bank accounts	$	$
Money market accounts	$	$
Other income	$	$
Total Monthly Family Income	$	$

Additional Comments:

Disclaimer: I understand that the information I provide will be used only to determine financial responsibility for my charges and will be kept confidential. I understand that the materials I send to prove my income and assets will not be returned. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by the IF Financial Assistance Fund including, as necessary, obtaining financial information from employers, banks, and other entities listed by me in this application. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval and I will be liable for the full amount of all charges.

My signature authorizes the IF Financial Assistance Fund to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.

Signature: ____

Relationship to patient: ________________________________

Date: ____

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