



GOULD FARM

Since 1913 · We Harvest Hope

www.gouldfarm.org

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Phone: 413-528-1804
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Partnership Financial Form

This form is to be completed by family member accepting responsibilities delineated below:

Financial assistance is available on the basis of family income.

As parent / spouse / relative, I promise that I will: (circle correct term)

- 1) Be financially responsible for debts incurred by the client while in the program, including any medical expenses not covered by insurance. The program fee does not include psychiatrist/medical fees, medication, dry cleaning, dental care, personal & entertainment costs, transportation, phone calls, etc. Fees are charged from day of admission through the date personal effects are removed from the room at formal discharge. No allowances are made for vacations, hospitalizations, or leaves short of discharge.
- 2) At the request of the Clinical Director, come for the client at once if he or she must leave for medical, psychiatric, legal or behavioral reasons, or if the client does not wish to remain in the program.
- 3) Either pay the full \$245 per day fee, (\$255 effective on May 1, 2010) or that fee determined by evaluation of my application for financial aid. I agree to make payments monthly, in advance, immediately upon receipt of statement.

One month's advance deposit is required. Fees paid to Gould Farm for care may be deductible as medical expenses for federal income tax purposes. Consult your tax advisor for a determination.

_____ I will pay the fee of \$245 per day (\$255 effective on May 1, 2010)

Date: _____

_____ I am requesting financial assistance. (Please complete application and attach a copy of your most recent federal 1040 form)

Signature of Financial Partner _____ Relationship to Client _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business _____
Cell _____

Email _____

Alternate Email _____

Name of Client _____ Client's Date of
Birth _____

Client's Social Security Number _____

Medical insurance-not applicable to program fees (for psychiatrist's fees & medication only)

_____ Medicare

_____ Medicaid

_____ BC/BS

_____ Other

Please attach copies of insurance cards.

Application for Financial Aid

(attach documentation to verify amounts)

Patient Social Security Disability \$ _____
S.S.I. \$ _____
Interest & Dividends \$ _____
Employment \$ _____
Current amount in savings account \$ _____
Current amount in checking account \$ _____
Other income \$ _____

Please submit copies of 1) Birth certificate
2) Social Security card
3) Most recent income tax return

Parent/Spouse Resource

Is 1040 form attached? _____ No? (explain) _____

List your dependents and their ages _____

Do you own your home? _____ Year purchased _____

Purchase price \$ _____ Unpaid mortgage \$ _____

Other real estate: _____

Personal savings \$ _____ Bank _____

Checking accounts \$ _____ Bank _____

Make and year of all cars/boats _____

Any special family circumstances may be described on a separate sheet.

To Be Signed by Parents or Spouse

We declare that the information reported on this form, to the best of our knowledge, is true, correct and complete. We grant permission to verify the information reported. We agree to notify Wm. J. Gould Associates of any changes in the above. We understand our financial agreement will be reviewed and may be changed and we agree to submit 1040 forms by May 1st each year.

Signatures: (father) _____ S.S.# _____
(mother) _____ S.S.# _____
(spouse) _____ S.S.# _____