



www.gouldfarm.org

100 Gould Road, P.O. Box 157
Monterey, MA 01245-0157

PARTNERSHIP FINANCIAL FORM

Phone: 413-528-1804
Fax: 413-645-1022

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

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

- 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 Program or 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) Pay the full \$295 per day fee, or that fee determined by evaluation of my application for financial aid. I understand eligibility for financial assistance is evaluated on the basis of complete financial disclosure of family and client income and resources. I agree to make payments monthly, in advance, immediately upon receipt of statement.

A month's deposit is required at intake. Fees paid to Gould Farm for care (not room and board) may be deductible as medical expenses for federal income tax purposes. Consult your tax advisor for a determination.

_____ I will pay the fee of \$295 per day Date: _____

_____ I am requestng financial aid. (Second page is required). Date _____

Print name(s) of Financial Partner(s) _____

Signature _____ Relationship to Client _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business _____

Cell _____ E-Mail _____

Name of Client _____ Client's date of Birth _____

Client's Social Security Number _____

Medical Insurance Coverage: Attach copies of all cards, front and back:
Insurance does not cover program fee stated above.

Insurance _____ # _____

Insurance _____ # _____

Application for Financial Aid

Attach documentation to verify amounts

CLIENT INFORMATION

Social Security Disability (SSDI) \$ _____
Supplemental Security Income (SSI) \$ _____
Interest & Dividends \$ _____
Employment \$ _____
Current amount in savings account \$ _____
Current amount in checking account \$ _____
Other income \$ _____

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

PARENT INFORMATION: MOST RECENT 1040 FORM MUST BE ATTACHED

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 _____

To Be Signed by Family Member(s) in Partnership

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 upon request.

Father _____ S.S.N. _____ Date _____

Mother _____ S.S.N. _____ Date _____

Spouse _____ S.S.N. _____ Date _____