Dear Applicant:

We commend you on your decision to seek treatment for your disease. You have indicated a desire to receive financial assistance for the cost of treatment. It is our policy to provide *partial* assistance, the extent of which is determined by a review of the enclosed application.

Complete the enclosed application and return it to Another Solution, Inc. as soon as possible. Upon receipt, your application will be reviewed to determine eligibility. You will be contacted by one of the board members when the review is complete.

We support your decision to seek treatment. If you have any questions regarding the program, please contact us.

Sincerely,

Lois Jordan

Board Member

Enclosures

CONDITIONS OF FINANCIAL ASSISTANCE

Please read, sign, and date the following:

I acknowledge that I am applying for financial assistance for treatment.

I acknowledge that approval for such assistance is required prior to my admission.

I acknowledge that assistance will be based upon:

1. Financial need as established by information received in the application for assistance.

2. Availability of funds.

3. Satisfactory progress in treatment (following the direction of the treatment team).

4. Successful completion of treatment. I may be responsible for all treatment costs incurred if I choose to leave treatment against medical advice or if I am asked to leave at staff request for being disruptive in treatment.

5. Willingness to follow aftercare recommendations.

6. A statement as to why you need financial assistance. Tell us why you would benefit from treatment.

I acknowledge that my portion of the account must be paid in full upon my admission to treatment.

I acknowledge that I can receive financial aid from Another Solution, Inc. *one time only*.

I declare this application has been honestly and correctly completed by me. I understand and give consent to Another Solution, Inc. to contact others and me to verify the information that I have provided. I agree to notify Another Solution, Inc. in writing with any changes regarding my financial situation.

I acknowledge that verification of this application may require disclosure that I have applied for treatment.

In the event that I have failed to disclose any assets or income, I acknowledge that I will be ineligible for financial assistance for treatment.

Note: Your application will not be processed without supporting documentation including your personal statement, income tax returns, and/or other documents showing your income. A written referral from a close friend or relative confirming your need for financial assistance will also facilitate your application.

_____ _____

Date Signature

REQUEST FOR FINANCIAL ASSISTANCE

***PERSONAL INFORMATION** (Applicant)*

LAST	FIRST	MIDDLE	SOCIAL SECURITY #	DATE OF BIRTH

STREET ADDRESS AND APT. #	CITY	STATE	ZIP CODE	PHONE NUMBER

NO. OF DEPENDENTS (Exclude self):	MARITAL STATUS (Circle one) M S D W SEP	RESIDENCE STATUS (Circle one) OWN HOME BUYING RENTING	PAYMENT $

OTHER SOURCES OF EXPENSE (Child support, Social Security, etc.)

EMPLOYER NAME AND ADDRESS	POSITION	WORK PHONE NO.	HOW LONG? Yrs Mos	TOTAL HOUSEHOLD GROSS INCOME PER MONTH $

OTHER SOURCES OF INCOME (Child support, Social Security, etc.)	TOTAL FOR LAST 3 MOS. $	TOTAL FOR LAST 12 MOS. $

***BANK ACCOUNTS** (Please list all accounts you maintain and/or to which you have access.)*

NAME OF FINANCIAL INSTITUTION (Office and address)	ACCOUNT NO.	ACCOUNT TYPE (Circle one) checking savings	BALANCE $
NAME OF FINANCIAL INSTITUTION (Office and address)	ACCOUNT NO.	ACCOUNT TYPE (Circle one) checking savings	BALANCE $

***CREDIT HISTORY** (Please list all accounts you are responsible for or to which you have access. Write on back if needed.)*

FIRST MORTGAGE (Name and address)			SECOND MORTGAGE (Name and address)		
MORTGAGE LOAN NO.	BALANCE	MONTHLY PAYMENT	MORTGAGE LOAN NO.	BALANCE	MONTHLY PAYMENT
AUTO #1 (Year & Model)	BALANCE	MONTHLY PAYMENT	AUTO #2 (Year & Model)	BALANCE	MONTHLY PAYMENT
AUTO #1 FINANCED BY (Name and address)			AUTO #2 FINANCED BY (Name and address)		
CREDIT CARD COMPANY		ACCOUNT #	CREDIT CARD COMPANY		ACCOUNT #

OTHER LOAN AGENCY	ACCOUNT #	MONTHLY PAYMENT $	BALANCE $

HOSPITAL BILLS Facility name:	BALANCE $	DOCTOR BILLS Doctor's name:	BALANCE $

MEDICAL COVERAGE

INSURANCE NAME AND BILLING ADDRESS	POLICY #	PHONE NUMBER

I affirm that the above information is true and correct to the best of my knowledge. Another Solution, Inc. is hereby authorized to make any investigation of my personal history and financial and credit record through any investigative or credit agencies or bureau of their choice. The provisions of the Fair Credit Reporting Act will be applicable if a credit report on the applicant is obtained and considered.

Date: _____ Applicant's signature: _____ Date application received by ASI: _____