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# Financial Aid Program INSTRUCTIONS



Dear Family Members:

Thank you for your interest in Skyland Trail. Through the generosity of Skyland Trail donors and friends, we offer a financial assistance program to help clients and families who meet need-based financial criteria.

Please find award guidelines and an application for financial aid attached. In order for the Financial Aid Committee to consider your application, all required information must be provided by and on behalf of the Financially Responsible Party (i.e. Guarantor) for the client, and not by or on behalf of the client admitting to Skyland Trail. Application requirements are outlined in the Financial Aid Program Guidelines on page two (2) of this document.

In order to help as many clients and families as possible, all applications for financial assistance are carefully reviewed to ensure that each aid recipient has demonstrated financial need. Once the completed Application Form and requested information are received by Skyland Trail, please allow 5 business days for review.

**Please return your completed application by email to:** [financialaid@skylandtrail.org](mailto:financialaid@skylandtrail.org)

**Or by mail to:** Finance Department, Skyland Trail, 1961 North Druid Hills RD NE, Atlanta, GA 30329

**Or by fax to:** 404-315-9838

Again, thank you for your interest in Skyland Trail. We appreciate your assistance in this application process and look forward to hearing from you.

Sincerely,

A handwritten signature in blue ink that reads 'Patty Reid'.

Patty Reid  
Secretary  
Board of Directors

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# Financial Aid Program GUIDELINES



Skyland Trail understands that investing in your loved one's mental health requires a significant commitment, both emotionally and financially. While those clients and families who demonstrate the greatest financial need will receive the most financial assistance, Skyland Trail makes every effort to help as many families as possible.

## AMOUNT OF AWARD

Please note that the amount of financial assistance awarded cannot exceed the amount of your financial responsibility. Therefore, financial aid does not apply to program fees that are considered in-network by your insurance provider or for which you receive reimbursement from your out-of-network benefits.

## FINANCIAL AID AND PROGRAM FEES

Financial assistance only applies to program fees that are NOT covered by insurance. Financial assistance does not apply to the following expenses and professional services:

- Co-pays\*
- Coinsurance\*
- Deductibles\*
- Admission Fee\*
- Family Orientation\*
- Labwork
- Psychological testing\*
- Medications
- Wellness services provided in or by the Glenn Family Wellness Clinic\*
- Preventive, urgent or specialized healthcare services rendered and billed by third party healthcare providers

\* *Adult Program Only*

## APPLICATION

To maximize the financial aid benefit to the recipient, Skyland Trail encourages families to complete the Financial Assistance Application during the client's admission process, but applicants may submit the application at any time during the client's treatment. The person responsible for paying the treatment costs (the Financially Responsible Party or Guarantor) should provide his or her financial information to complete the application and the Personal Financial Statement. If a second Financially Responsible Party is required, an additional Personal Financial Statement and Federal Income Tax Returns for the most recent three (3) years must be submitted for that individual as well.

### A complete application packet includes:

- Skyland Trail **Financial Aid Program Application Form** (page 3 of this document)
- Skyland Trail **Personal Financial Statement** for the Financially Responsible Party and any other individuals responsible for payment of treatment costs (page 4 of this document)
- **Federal Income Tax Returns** for the last three (3) years for the Financially Responsible Party or Parties (please send only the first two pages of each return)
- A **letter from the Financially Responsible Party** describing any special circumstances is strongly encouraged

## APPROVAL PROCESS

Once the completed Application and requested information are received by Skyland Trail, please allow approximately 5 business days for review. If approved, the financial aid discount will be applied beginning the day the award is approved.

# Financial Aid Program APPLICATION FORM



## Client Information

Client Name:	
Client Address:	

## Financially Responsible Party

Name:			
Address:			
Email:		Phone:	

List all individuals who provide financial support to the client in addition to the financially responsible party. Please include name, address, and phone number.

Name:			
Address:		Phone:	
Second Financially Responsible Party <input type="checkbox"/> YES <input type="checkbox"/> NO			

Name:			
Address:		Phone:	

Select the program(s) to which you are applying for scholarship funding.

<b>Adolescent Programs (ages 14 to 17)</b>
<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Day Treatment (PHP) <input type="checkbox"/> Intensive Outpatient Program (IOP)

<b>Adults Programs (ages 18+)</b>
<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Day Treatment (PHP) <input type="checkbox"/> Transitional Living <input type="checkbox"/> Intensive Outpatient Program (IOP) <input type="checkbox"/> Independence Coaching <input type="checkbox"/> Vocational Services <input type="checkbox"/> LEAP / Social Enrichment

Do you intend to contract with SJ Health Insurance Advocates to coordinate reimbursement for any out-of-network benefits for residential or day treatment?  Yes  No

(Adult Clients Only) Does the client have in-network insurance coverage for non-residential treatment?  Yes  No

\_\_\_\_\_ (PLEASE INITIAL) I have read and understand the Financial Aid Program Guidelines (pg 2).

# Financial Aid Program

## PERSONAL FINANCIAL STATEMENT



Please complete with information for the **Financially Responsible Party (not with the client's information)**. Separate Personal Financial Statements are required for the Financially Responsible Party, a second Financially Responsible Party (if required), and any other individual(s) responsible for payment.

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Guarantor Total Monthly Income		Guarantor Assets	
Net Salary		Checking Account	
Business Income		Savings Account	
Social Security		Real Estate Value	
Pension/Annuities		Certificate of Deposit	
Investment Income		IRA	
Trust Fund		Retirement Investments	
IRA		Trust Fund	
Rental Property		Personal Property	
Gifts		Other Investments:	
Alimony			
Other			
<b>Total Monthly Income:</b>		<b>Total Assets:</b>	
Guarantor Total Monthly Expenses		Guarantor Liabilities	
Food		Home Mortgage	
Clothing		Credit Cards / Charge Accts	
Shelter (rent or mortgage)		Loans	
Utilities / cell phone		Debts (guaranteed debt)	
Auto		Other Debts	
Medical Expenses		Taxes Owed	
Prescription Drugs			
Insurance			
Child Care			
School Tuition			
Child Support			
Loan Payments (itemize)			
Real Estate Taxes (estimated annual taxes ÷12 months)			
Other:			
<b>Total Monthly Expenses:</b>		<b>Total Liabilities:</b>	
<b>Discretionary Funds:</b> (monthly income minus monthly expenses)		<b>Net Worth:</b> (assets minus liabilities)	

**SIGNATURES:** I hereby state that the information provided is accurate and complete to the best of my ability. Skyland Trail reserves the right to verify all information provided.

Applicant (Guarantor) Signature:		Date:	
Relationship to client:			