Catalpa Health
Mental Health & Wellness For Kids
Ascension Wisconsin · Children's Wisconsin · ThedaCare

Dear Catalpa Parent and/or Legal Guardian,

Enclosed please find a Catalpa Cares Application.

Catalpa Health has established certain eligibility based on the Federal Poverty baselines. Acceptance will be granted consistently and equally to all patients who meet this criteria.

Assignment of all health insurance benefits is required before eligibility can be considered.

Please return the completed application along with all the necessary information on the enclosed checklist within 15 days. A representative from Catalpa Health will be in touch with you once your application is received and reviewed.

If you have any questions or need assistance in completing the application, please call.

Sincerely,

Nicole Wohlt
Catalpa Cares Coordinator

P: (920) 702-3411
F: (920) 882-5495

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Services: Clinic _____ School _____ IOP _____

Name of Patient/s you are requesting assistance for: _____D.O. B. _____

_____D.O. B. _____

Account Number: (if known) _____

Total Balance Due (if known) $_____

- Section 1 -

Personal Information:

Name of Guarantor: _____

Name of Spouse: _____

Address: _____

Home Phone: _____ Cell: _____

List **YOUR** dependents under the age of 18 **LIVING** with you:

Name	Age

Did you have Medical Insurance Coverage or Medical Assistance any time in the past year? ☐ Yes ☐ No

Name of Coverage	Member/Subscriber ID#	Subscribers Name	Effective Date:

- Section 2 -

Financial Information: Please list monthly gross income for each section. (Gross – before taxes and deductions)

Employer's Name and Phone Number	**Guarantor**	**Spouse**
Job Title		
Salary (Monthly Gross)		
Social Security Income		
Pension Plan		
Other Income (Alimony, Child Support, Etc.)		

Please detail any extenuating circumstances you feel would be beneficial when reviewing your application (Please feel free to attach additional pages):

_____

_____

_____

_____

I authorize Catalpa to verify all information presented in this application, including, but not limited to: Employment, Insurance and Income verification. I understand that any false or misleading information will void this application and exclude me from financial assistance. I certify that the information submitted is true and correct and that all known assets and liabilities have been listed.

_____ _____

Signature of person completing this Application Date

_____

Relationship to Guarantor

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CHECKLIST

This checklist is provided for you to use prior to returning this application. To process your application please make sure to include copies of the following:

☐ Your previous years Federal Tax Return (If you do not have a copy of this, you can obtain a copy by calling the IRS at 800-829-1040, or on their website http:/www.irs.gov.)

☐ check here if you did **NOT** file taxes during the previous year

☐ If you are claimed on someone else's taxes as a dependent, please identify that person

Name: _____ Relationship: _____

☐ Your Employment Stubs for the previous 3 months (payroll or unemployment, etc.) If you do not have them, your employer should be able to provide you with them.

☐ Other Income (examples: child support, alimony, social security, or pension income)

☐ Written denial from Medical Assistance. (If Applicable)

☐ Did you remember to complete the entire application, including **Sections 1 & 2**?

☐ Did you remember to sign the application?

☐ Did you remember to return this Check List with all the requested information?

☐ If someone other than yourself has prepared this form, may we have your permission to discuss this matter with them should we have any questions? ☐ Yes ☐ No

If yes, please provide their name & phone number _____

4635 W College Ave. Appleton, WI 54914-8507