Today's Date (MM/DD/YYYY)	
Medical Record #:	
Guarantor #:	
Referred By:	

ThedaCare

CARING HEARTS APPLICATION

Send to: PO Box 8003
Appleton WI 54912

Applicants Name *(First, Middle, Last)*

HEALTH INSURANCE If yes, please provide information and copy of insurance card

Insurance Co Name and Address:	Policy Number:

PLEASE CHECK ALL BOXES BELOW THAT APPLY AND PROVIDE SUPPORTING DOCUMENTATION

☐ Medicaid Eligible, but not for date of service or for non-covered service	☐ Incarceration in penal institution
☐ Homeless – Explain:	☐ Work Comp/TPL related charges
☐ I participate in a Cost Share program	

PLEASE ATTACH COPIES OF THE FOLLOWING REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION

☐ Copies of checking and savings bank statement for last 60 days	☐ Submit a letter describing your financial situation
☐ Copies of pay stubs for 60 Days for all income reported	☐ Copies of Social Security Benefits (if applicable)
☐ Copies of unemployment statements for 60 days	☐ Profit & Loss statement if self employed
☐ All Pages of MA response dated within last 6 months	

Filed Federal income taxes? To request a copy of your taxes, please call 1-800-829-1040

☐ Yes – Please send the most recent Federal income tax returns and supporting schedules.
☐ No – Please explain why:

Include all 1040 schedules including schedule C, K, and E if you are self-employed.

I have applied for or will apply for federal or state medical assistance

☐ Yes ☐ No – Not a citizen ☐ No – Over income ☐ No – Other reason, why?

Email Preference:

I understand that unencrypted email is not a secure form of communication and that there is some risk that the information contained in emails may be misdirected, accessed, or intercepted by unauthorized third parties. I request that Thedacare communicate information related to this Financial Assistance Application with me via email. I understand that I can revoke this request at any time in writing or by contacting Customer Service @ 1-800-236-4102	☐ Yes ☐ No
Email Address:	

PATIENT/RESPONSIBLE PARTY

Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Name *(First, Middle, Last)*	Social Security Number	Birth Date *(MM/DD/YYYY)*	
Street Address	City	State	Zip Code
Phone Number:	Household Size *(Patient, Spouse & Dependents)*		
Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name and Address		
Hire Date: *(MM/DD/YYYY)* / Position:	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐ Yes ☐ No If yes, provide tax return of those claiming you.	
Unemployed: *(MM/DD/YYYY)* From: To:	Average Gross Monthly Income: $	Monthly SSI/SSDI: $	

SPOUSE (If applicable)			
Name *(First, Middle, Last)*	Social Security Number	Birth Date *(MM/DD/YYYY)*	Phone Number:
Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name, Address, and Phone Number:		
Hire Date: *(MM/DD/YYYY)* / Position:	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐ Yes ☐ No If yes, provide tax return of those claiming you.	
Unemployed: *(MM/DD/YYYY)* From: To:	Average Gross Monthly Income: $	Monthly SSI/SSDI: $	

DEPENDENTS (If more than 4 dependents use a separate page) (Note if claimed every other year)				
Full Name	**Relationship**	**Birth Date *(MM/DD/YYYY)***	**Claimed as a Dependent on Taxes**	
1.			Yes	No
2.			Yes	No
3.			Yes	No
4.			Yes	No

OTHER MONTHLY INCOME (Please attach copies of your documents to support this income)					
Other Wages	$	Rental Income	$	Unemployment	$
Pension	$	Disability Income	$	Interest/Dividends	$
Misc. Income	$	Veterans Benefits	$		

ASSETS			
Checking Balance	$	Savings Balance	$

CERTIFICATION: I certify the preceding income/expense information is true and correct. Please be aware we may review the information you provided in conjunction with your credit report. I understand if I knowingly provide untrue information in the application, I will be ineligible for financial assistance and the financial assistance granted to me may be reversed and I will be responsible for the medical bills.

SIGNATURE REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED	
Patient/Responsible Party Signature	Date
Spouse (If applicable)	Date