SUBMIT TO
CARENAVIGATOR@WELLPOINTCARE.ORG

Financial Assistance Application

Wellpoint Care Network's Financial Assistance Program was developed to ensure equitable access to behavioral health services. Sliding scale discounts are made available based on family size and household income. Decisions are made without the consideration of race, color, national origin, age, disability, sex, religion, language, ethnicity, socio-economic status, sexual orientation, gender identity, veteran's status, political beliefs or other identity.

Wellpoint Care Network Behavioral Health Clinic does not deny service due to inability to pay. If assistance is required, please complete this application and follow the guidelines below:

- This application must be accompanied by proof of income to be processed. Accepted forms include prior year's tax return, W2, or two most recent pay stubs. If you are unable to provide this information, contact the Care Navigation Team at carenavigator@wellpointcare.org
- Once financial assistance has been received, the applicant shall return the application within 14 days, or work with a Care Navigator additional time is needed. If the application is not received, approval will begin on the date the application is received and not backdated.
- Once the application is processed, a letter will be sent to the applicant outlining the determined discount. Upon receiving this letter, the applicant is expected to establish payment arrangements for any remaining responsibility.
- The applicant may submit a re-determination request, if the determined responsibility causes continued financial hardship. This request shall provide an explanation of need, and can be made to applicant's therapist or a Care Navigator. Wellpoint Care Network's Vice President of Clinical Services will review the request and a letter will be mailed out with the decision.
- Individuals must re-apply for financial assistance every 12 months, or sooner if their financial situation changes. For full program details, see Wellpoint Care Network's Financial Assistance Policy and Procedure document.
- If you need assistance or accommodations to complete this application, please contact us at 414-465-5770 or carenavigator@wellpointcare.org

Person Completing Form:	**Relationship:**
Contact Phone:	**Contact Email:**
Person Receiving Services:	**DOB:**

Household Income	Self	Spouse	Total
Annual Income (from W2)			
Unemployment, SSI, retirement, or other benefits (SNAP/WIC or other non-cash benefits do not count)			
Alimony, child support, interest, dividends, rents, income from trust			

State Assistance:	Yes	No	Need Help Applying
WIC or SNAP			
Medicaid/Medicare/Badgercare			
Other assistance			

Household Members/Dependents:

Name	Relationship	Age	Dependent (yes/no)

Extenuating Circumstances (medical bills, disaster etc.): _____

_____

_____

_____

_____

I hereby certify that the provided information is true and accurate:

Print Name:	Date:
Signature:	

Office Use Only:

Date Received:	
Total Income:	
Total Family Size:	
FPG %:	
Price per visit:	

Financial Assistance Agreement

Wellpoint Care Network is pleased to offer Financial Assistance in collaboration with Care Navigation services to individuals without health insurance to prevent an interruption in services. Wellpoint Care Network's Financial Assistance Program does not replace benefits available from other available payment sources. Our Care Navigation team is available to assist you in applying for the appropriate insurance coverage, or you may choose to find coverage independently. Listed below are the expectations of your choice. These expectations must be met for financial assistance to remain active until alternative coverage is found.

Please select your preference and initial on each line to indicate you understand the expectations.

☐ I choose to work with a Care Navigator. **I understand the following:**	**☐ I choose to obtain coverage independently.** **I understand the following:**
_____A Care Navigator will be contacting me to assist with my insurance coverage. _____It is my responsibility to stay in communication with my Care Navigator and return any missed contact within one week. _____It is my responsibility to keep all scheduled phone and in-person appointments. If I must reschedule, proper notice will be given. ____If I do not meet these communication expectations, my financial assistance approval may be terminated, and I will be responsible for uninsured sessions at the self-pay rate.	_____If re-enrolling in Medicaid, it is my responsibility to request my coverage be backdated to date of lost coverage. If I do not request my insurance coverage be backdated, I may be responsible for costs incurred during this lapse in coverage. _____If applying for insurance through Marketplace and I wish to continue services at Wellpoint, it is my responsibility to choose a plan that is in-network. If further information is needed to make this decision, a Care Navigator is available to assist me. _____ I must send proof of my application submission to a Care Navigator within one week of being approved for Financial Assistance. If the application is not received, a Care Navigator will contact me to offer assistance. _____I may elect to work with a Care Navigator at any point during this process. _____ If I do not meet these expectations, my financial assistance may be terminated, and I will be responsible for uninsured sessions at a self-pay rate.