WAIVED FEE REQUEST

Customer Name _____ Case # _____

- I accept service and agree to provide the information requested in accordance with this document.
- I agree to inform Catalpa Health of any changes in my insurance or financial situation that may negate the need to waive my fees and not interrupt services.
- I understand Catalpa Health may still bill my insurance where applicable.

APPLICATION FOR FINANCIAL ASSISTANCE

Catalpa Health receives funding that allow us to consider waiving fees for which you are responsible because funds allows us to support these fees in certain situations where services to children and families would not be possible. To assure fair and proper use of these limited funds, we request financial information to determine and document the need for this support.

The reason I am requesting financial assistance is: (please check appropriate box)

[ ] I cannot afford my co-pay.

[ ] I cannot afford deductible.

[ ] I have exceeded the maximum annual insurance benefit.

[ ] (other – briefly explain)_____

Income on 1040 or Homestead:_____ Dependents claimed:_____

To the best of my knowledge, the information I have provided is true and correct. I understand that Catalpa Health may still bill my insurance and that donor funding will support my portion of the fees. I further understand that it is my responsibility to notify Catalpa Health of changes.

Signature of Customer (Guardian): _____

Date: _____

Catalpa Health Business Manager _____

Date: _____