Waupaca County Department of Health & Human Services
Behavioral Health Services
CONSUMER APPLICATION

811 Harding St | Waupaca, WI 54981 | (715) 258-6300 | Fax: (715) 258-6409

Applicant: **Last Name** **First Name** **Middle Name**			**Date:**
Maiden Name or Previously used last name:			**Soc. Sec. #:**
Phone: Home: ( ) Cell: ( ) Work: ( )			**DOB:**
Home Address:			**City:**
Age:	Grade:		
Identified Gender: ☐ **Female** ☐ **Male** ☐ **Transgender** ☐ **Agender** ☐ **Non-gender**			
Preferred Pronouns: ☐ **She/her** ☐ **He/him** ☐ **They/them** ☐ **Ze/hir**			
Guardian/Responsible Party:	Relation:	Contact:	
Guardian Address	City:		
Referred by:	**Family Physician:**		

Preferred Appointment Timeframe: ☐ **8 am - 12 pm** ☐ **12 pm - 4 pm** ☐ **Other:**	
Religion:	**Deaf or Hard of Hearing:** ☐ **Yes** ☐ **No**
Primary Language Spoken:	**Highest Educational Level:**
Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Never Married ☐ Separated ☐ Widow(er)	
Heritage: ☐ African American ☐ Hispanic ☐ Native American ☐ White ☐ Asian ☐ Biracial ☐ Other:	

Previous Mental Health and/or AODA Diagnosis:

Reason for seeking care:

Other Professionals you are currently working with (including DHHS staff not in the Behavioral Health Unit)			
Name	Profession	Dates Seen	Phone

Household Members: Please list everyone who lives with you			
Name	Birthdate	Relationship	Monthly Income/Source

Insurance: ☐ Badgercare/Medical Assistance ☐ Medicare ☐ No Insurance ☐ Other:	
PLEASE PROVIDE A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD	
Medicare HIC#:	MA#:
Other Insurance Name:	Policy #:
Other Insurance Address:	Group #:
Policy Owner (if not applicant):	DOB:
Address:	SSN:
Relationship to Client: ☐ Parent ☐ Spouse ☐ Stepparent ☐ Other:	

Monthly Income	
Child Support, Disability, Social Security, SSI, UC, Other	$
Earnings: Name of Employer(s):	$
Court Ordered Obligations	$
Monthly Total:	$

Please Read and Initial the following Statements:	
	I hereby authorize any physician or therapist who provides services to me to disclose, when required by the insurance company or its representatives, any and all information with respect to my preset condition, medical history, consultation or treatment.
	I am aware there are charges for the behavioral health services. There will not be a charge to me if my insurance covers all services. However, I will be financially responsible for any charges from my insurance, such as copayment, coinsurance or deductible amounts.
	I am aware that it is my responsibility to provide my insurance card and report any changes of insurance to avoid being held responsible for all charges. Waupaca County will submit billing directly to my insurance company with payments going directly to Waupaca County.
	If I do not have insurance my payments will be based on my ability to pay using the state sliding fee scale. I will receive written notice if I have a monthly payment obligation. My ability to pay will be reviewed annually; Waupaca County will provide me a review notice when needed. I understand that not completing the financial form or notifying Waupaca County of financial changes may lead to be being billed for all charges.
	I understand that if I am found to have a zero ability to pay, that I will still accrue a balance that is owed to Waupaca County and that my ability to pay this balance due will be reviewed on a yearly basis. This balance will be reflected in my monthly statements from the financial department.
	I understand the full charges for services with a doctor are $346.00 per hour and a therapist $274.00 perhour.
	I have received the financial responsibility for outpatient services brochure.

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Client Signature Date

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Spouse/Parent/Guardian Date