Navigating your financial medical crisis journey

CBT FAMILY APPLICATION

NOTE: All questions **MUST** be completed. An incomplete application will be rejected and will delay the approval process. For any questions or help filling out the application please call **920.422.1919** or email **info@communitybenefittree.org**

SECTION 1 - General Information

Recipient Information *(Recipient is person with medical issue.)*

Name *(please include middle name)***:** ______________________ **Date of Birth:** ____________

Please provide your SSN or copy of a certified birth certificate: ______________________

Street Address: ______________________ **City:** ____________

State: ________ **Zip:** ________ **County:** ______________________

Phone 1: ____________ **Email:** ______________________

Employer Name: ______________________

[ ] **Yes**, I am a veteran or in the military *(Please submit your DD214 Form)*

Spouse Information

Name: ______________________

Street Address: ______________________ **City:** ____________

State: ________ **Zip:** ________ **County:** ______________________

Phone 1: ____________ **Email:** ______________________

Employer Name: ______________________

[ ] **Yes**, I am a veteran or in the military *(Please submit your DD214 Form)*

Parent/Guardian Information *If child both parents MUST completely fill out and sign application.)*

Name 1: ______________________

Street Address: ______________________ **City:** ____________

State: ________ **Zip:** ________ **County:** ______________________

Phone 1: ____________ **Phone 2:** ____________ **Email:** ______________________

Employer Name: ______________________

Name 2: ______________________

Street Address: ______________________ **City:** ____________

State: ________ **Zip:** ________ **County:** ______________________

Phone 1: ____________ **Email:** ______________________

Employer Name: ______________________

[ ] **Yes**, I am a veteran or in the military *(Please submit your DD214 Form)*

How many people currently live in your household *(Adults/Children)***:** ________

Dependents of responsible party *(If recipient is the same as responsible party please fill in spouse information for recipient and name, age, and relationship)*

Name: ____________ **Age:** ______ **Relationship** *(to responsible party)***:** ____________

Name: ____________ **Age:** ______ **Relationship** *(to responsible party)***:** ____________

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Name: ______________________ **Age:** ______ **Relationship** *(to responsible party)***:** ______________________

Name: ______________________ **Age:** ______ **Relationship** *(to responsible party)***:** ______________________

Have you ever been convicted or have charges pending of a crime *(felony or misdemeanor)***:** [ ] Yes [ ] No

If yes, please fill out the following:

State in which convicted: ______________________

Date of conviction: ______________________

Nature of the crime: ______________________

____

We conduct criminal record checks on all of our recipients. Convictions are not an automatic bar to being approved. However, failure to provide complete and accurate information relating to criminal convictions will result in immediate removal of assistance. If your are unsure how to complete this information, please contact us.

How did you hear about Community Benefit Tree *(ex: Facebook, 211, family member, friend, past recipient, etc...)***:**

____

SECTION 2 - Program Information

What is your medical diagnosis: ______________________

____

Please fill in area you are requesting assistance with:

Needs Are: [ ] One time assistance [ ] Ongoing assistance

Rent $: ________
Groceries $: ________
Handicap equipment/vehicle $: ________
Utilities $: ________
Gas $: ________
Loan Payment(s) $: ________
Medical Bills $: ________
Prescription(s) $: ________
Phone $: ________
Cable/Internet $: ________
House Repairs $: ________
Credit Card Payment(s) $: ________
Vehicle Repairs $: ________
Other *(description and cost)* $: ______________________

Please list any Prayer Requests you may have:

____

____

____

Please check any of the following CBT programs you would like to receive more information about:

[ ] Supportive Listening Session *(a time to be heard)*

[ ] Financial Sustainable Plan *(planning for short and long term plans for your financial medical crisis)*

[ ] Fundraising *(resource with planning a benefit, fundraising website page,etc...)*

[ ] Resale *(selling your unwanted items in our thrift store)*

[ ] Education Classes

If awarded financial assistance are you willing to give a testimonial *(answer does not effect eligibility)***:** [ ] Yes [ ] No

If yes, please select all that apply: [ ] Written [ ] Video [ ] In Person [ ] Photos [ ] All options

NAME *(internal use only)***:** ______________________

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SECTION 3 - Recipient & Caregivers Terms and Conditions

I hereby agree that everything I have stated in this application is true and accurate to the best of my knowledge, to abide by all the rules and regulations and that Community Benefit Tree, Inc. is relying on this application to make its decision in helping to assist me. I understand that this application can be rejected for incomplete information. Furthermore, I understand that Community Benefit Tree, Inc. is not obligated to accept my application for assistance. I hereby agree for Community Benefit Tree to share my information with other resource(s) to further benefit my financial situation.

NOTE: If recipient is under 18 both parents or legal guardian must sign:

Recipient Name *(please print)***:** ______________________________ **Date:** __________

Recipient Signature: ______________________________

Parent/Guardian Name *(please print)***:** ______________________________ **Date:** __________

Parent/Guardian Signature: ____________________ **Relationship:** ____________

Parent/Guardian Name *(please print)***:** ______________________________ **Date:** __________

Parent/Guardian Signature: ____________________ **Relationship:** ____________

SECTION 4 - Verification Information

Please submit the following attached forms:

- **Medical Provider Verification Form** *(needs to be completed by one of your medical providers)*
- **Personal Referral Form** *(needs to be completed by a non household member)*
- **Verify Income - provide 3 month's of current bank statements** *(example of current income proof: paystubs, ss ward letter, tax returns, etc...)*
- **DD214 Form**- Military Verification Form *(if applicable)*

NOTE: Referrals will be contacted prior to approval of your application.

CBT Contact Information:

Email: info@communitybenefittree.org

Phone: 920.422.1919

Fax: 920.462.4664

Address: 1734 Ken Dale Dr.
Kaukauna, WI 54130

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MEDICAL PROVIDER **VERIFICATION FORM**

Thank You for taking the time to fill out the referral letter in verifying the medical diagnosis. Please fill in each area and let us know if you have any questions or concerns at 920.422.1919.

Patient's Name *(please include middle name)***:** ______________________ **Date of Birth:** __________

Medical Diagnosis: ______________________

____

____

____

____

Medical Provider Name: ______________________

Medical Provider's Business Name: ______________________

Street Address: ______________________

City: ______________________ **State:** __________ **Zip:** __________

Phone : __________ **Email:** ______________________

I hereby agree that everything I have stated in this application is true and accurate to the best of my knowledge. And I understand I will be contacted for verification of this form.

Medical Provider Signature: ______________________ **Date:** __________

Return the referral letter to the patient or mail/fax it to CBT:

CBT
1734 Ken Dale Dr
Kaukauna, WI 54130
fax: 920.462.4664.

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SUPPORTER
REFERRAL LETTER
(MUST BE NON HOUSEHOLD MEMBER)

Thank You for taking the time to fill out the referral letter and in recognizing that the family is in need of assistance. Please fill each area and let us know if you have any questions at 920.422.1919.

Family's Name : ______________________________

Testimonial of why you feel the family could use support *(for more space write on back side)***:** ______________________________

____

____

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____

Your Name: ______________________________

Your Relationship to the Family: ______________________________

Street Address: ______________________________

City: ______________________________ **State:** ______________ **Zip:** __________

Phone : ______________ **Email:** ______________________________

I hereby agree that everything I have stated in this application is true and accurate to the best of my knowledge. And I understand I will be contacted for verification of the referral letter.

Your Signature: ______________________________ **Date:** __________

Return the referral letter to the patient or mail/email it to CBT:

CBT
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Kaukauna, WI 54130
Email: office@communitybenefittree.org