

APPLICATION FOR ASSISTANCE

Date _____

Applicant's Name _____ Phone _____

Address: _____ City _____ Age _____ Sex _____

If no phone, please give a name & phone number where a message can be left:

Employer _____ City _____ Phone _____

If unemployed, last date of employment _____

Marital status: Married _____ Single _____ Divorced _____ Widowed _____

Who referred you to the organization? Name _____ Phone _____

If applicant is a minor, parent's or legal guardian's name(s) _____

Address _____ City _____ Phone _____

Father's Employer _____ Work Phone _____

Mother's Employer _____ Work Phone _____

Has applicant received assistance from other organizations? _____

When? _____

Where? _____ Type of assistance? _____

Applicant's insurance co. (or parent's if minor) _____ Phone _____

May we contact your insurance company? Yes ___ No ___ How much of the estimated cost will your

insurance company cover? _____ Is applicant eligible for Medicaid or Medicare? _____

Total income of applicant or parent(s)? \$ _____ weekly _____ monthly _____ annual _____ other _____

Is applicant or parent(s) receiving any type of aid? (check each) public aid ___ welfare ___ food stamps ___

Social Security ___ Unemployment insurance ___ Union Benefits ___ Disability insurance ___ Other? _____

Monthly expenses: Rent or mortgage _____ Food _____ Utilities _____ Credit cards _____

Medical insurance _____ Car(s) payment(s) _____ Other _____

What assistance is requested from the organization? (please describe in detail)

(attach a separate sheet if necessary)

Urgency of need (this must be completed)

Does applicant currently have a doctor? Yes ___ No ___ If yes, complete below.

Dr. _____ Address _____ City _____ Phone _____

I, the applicant (or parent), understand that I may be interviewed by telephone, or in person, if additional information or if clarification of this application is needed. I have answered all questions to the best of my ability.

Applicant's signature

Parent or guardian signature

Date: _____

Thank you for contacting the organization. Our best wishes to you.



FOUNDATION USE ONLY

Date of Review _____ Member _____ Approved ___ Disapproved ___ Date _____

Reason if disapproved _____

Service approved _____ Amount \$ _____

Date letter of approval or disapproval sent to applicant _____

Referred to _____ Date Provider notified _____ Date of service _____

Date invoice paid _____ Notes: _____
