FINANCIAL AID APPLICATION

PERSONAL INFORMATION

Name ____
First Last

Address ____
Street

____
City State Zip Code

Phone ____
Home Cell Work

Email ______________________________ Date of Birth__________Sex F M

Health Insurance ____
Company Name of Primary

MEDICAL INFORMATION

Diagnosis ____

Date of Diagnosis __________ New Re-occurance Current Stage ______________

In Treatment: Yes No Type of Treatment ___________________________________

Reason for Assistance ____

____

Health Care Provider ____
Name

Address ____
Street

____
City State Zip Code

Phone ________________________ Email ___________________________________

Hospital/Clinic ____
Name

Address ____
Street

____
City State Zip Code

Phone ________________________ Email ___________________________________

FINANCIAL INFORMATION

Employer ______________________________ Self Family Member

Address ______________________________
Street

____
City State Zip Code

Gross Monthly Income ____________ Household Size ___ Ages ____________

Can someone else claim you as a dependent on their tax return? Y N

Have you applied for Social Security Disability Insurance Coverage? Y N

TYPE AND AMOUNTS OF FINANCIAL AID NEEDED (please be as specific as possible)

Medical Bills $ ________ Prescription Medicine $ ________ Home Care $ ________

Lodging $ ________ Transportation $ ________ Child Care $ ________

Rent/Mortgage $ ________ Insurance Premiums $ ________

Medical Bills $ ________ Other (please explain) ______________________________

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____

Name of person applying ______________________________

Phone ______________________________
Home Cell Work

Relationship to patient ______________________________

DISCLOSURE

Funds are limited and are distributed based on need, urgency and availability of funds. A Cure In Sight reserves the right to limit or deny any funds based on information provided. Any funds must be used for the purpose applied for and may be paid directly to the institution or organization providing the services funding is applied to. A Cure In Sight reserves the right to offer financial help in the form of a voucher or gift card. Any and all information provided to A Cure In Sight and its representatives will remain confidential and will not be shared with any agency or organization, with the exception of Federal Tax filings.

I the undersigned certify that to the best of my knowledge and belief, all information contained in this financial aid request is true, complete and correct. I agree that my undersigned electronic signature [typed name] is the legal equivalent of my manual signature.

Signed ____________________ Date __________ | ADMIN: Init. Rcvd.