

**Application for Financial Assistance**

All applications are kept confidential. FAITHKIDS cannot meet every request and cannot provide large gifts for medical procedures. However, some assistance is generally available for things such as transportation, housing, medication, insurance premiums and other needs. Families may be prioritized by need, but no family will be ineligible because of their income level. FAITHKIDS reserves the right and the Applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis.

*This form must accompany the Consent for Release of Protected Health Information for FAITHKIDS to provide assistance.*

**Section 1 – Patient Information:**

Name (First, Middle, Last):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street or PO Box, City, State, Zip):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_\_\_Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient have a drug plan?: Yes No

Name of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient have health insurance? Yes No

If yes, type: Managed Care Traditional Indemnity (circle)

Medicare Medicaid Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder (insured person): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible: Individual $\_\_\_\_\_\_\_\_\_ Family $\_\_\_\_\_\_\_\_

Approximate Length of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2 – Parent/Guardian Information**

MOTHER/GUARDIAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alt:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment (employer and nature of work/title):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gross Monthly Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER/ GUARDIAN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alt:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment (employer and nature of work/title):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gross Monthly Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOUSEHOLD LIABILITIES/INCOME INFORMATION

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

Total Monthly Income: $ \_\_\_\_\_\_\_\_\_\_\_\_\_ Total Monthly Liabilities: $ \_\_\_\_\_\_\_\_\_\_\_

Does patient or family receive assistance from other agencies? If so, list agencies and nature of assistance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to FAITHKIDS? Social Worker/Hospital Staff Website Another Assisted Family Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3 – Need Evaluation Please prioritize your family’s needs by numbering them 1-10**.

 \_\_\_\_\_ Housing/Rent/Mortgage \_\_\_\_\_ Clothing/Personal Items \_\_\_\_\_ Transportation \_\_\_\_\_ Overdue bills/utilities \_\_\_\_\_ Medicine/Prescriptions \_\_\_\_\_ Insurance Premiums \_\_\_\_\_ Child Care \_\_\_\_\_ Insurance Deductible Amounts \_\_\_\_\_ Groceries/Food \_\_\_\_\_ Counseling/Guidance/Support

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4 – Parent/Guardian Certification:**

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature and that any intentional misrepresentation of the information contained in this application will result in the loss of current and future assistance from FAITHKIDS and may result in civil liability. The Applicant hereby releases FAITHKIDS from any and all liability which may arise from the sharing of this information to third-parties.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature Date Relationship to patient



**Consent for Release of Protected Health Information**

Section 1 – Patient/Guardian Release I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Circle) Patient, Parent, Guardian, legal custodian of:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ (NAME OF PATIENT)

Authorize the physicians and staff of the facility or medical practice treating this patient to release to: FAITHKIDS. Treatment dates to be included in disclosure: \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_ All of the following medical information regarding this patient: Lab Reports Billing Records Radiology Reports Medical List/Invoice Reports of Treatment/Diagnosis Medications/Prescriptions The following other information or documents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Method by which information is to be released: EMAIL, Mail, Fax, Verbal Exchange, Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information is being released for the following purpose: To qualify for an award/contribution from FAITHKIDS Inc. a not for profit organization.

 Date, Event, or Condition when Consent Expires: Continuing Consent In the event no date, event, or condition is specified for expiration, this consent expires in ninety (90) days from the date of signing. I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon it. I freely and voluntarily give this consent.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

 X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of consumer, parent, guardian or authorized legal representative when required

Date Witness (Optional) Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Legal Representative’s Authority, if applicable.

Section 2 – Physician Certification:

I certify that that the patient listed in this application is currently receiving treatment from: (check one)

 Jimmy Everest Center, OU Physicians or OU Medical Center/Children’s Hospital; or

 St. Francis Hospital; or

 \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for a form of terminal illness. (name of hospital or treatment facility)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Name Physician Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Signature Date

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