Logo, company name

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**S.H.O.U.T International** Patient Assistance Application

[www.S.H.O.U.T.International.org](http://www.S.H.O.U.T.International.org)

Please fill out this application with honest and correct information to be considered a candidate for assistance. **You MUST sign and date the application on the bottom of the page and include ALL required documents. Applicants must be 18 or older to apply. Lack of complete documentation will disqualify you from receiving an award. You must be a scleroderma patient to qualify and be accepted.**

**PLEASE BE ADVISED AN APPLICANT WILL ONLY RECEIVE ONE AWARD!**

NAME**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

first/mi/last

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

street

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

city/state/zip

COUNTRY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

home cell/mobile

GENDER: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_ MARTIAL STATUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

m/f/other m/d/s/w

Are you a Scleroderma patient? \_\_\_\_\_\_\_\_\_\_\_\_ If, yes When were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_

yes/no (year)

Are you applying for someone else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ yes/no If yes, please fill out this section:

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

first/mi/last

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

street

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

city/state/zip

COUNTRY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

home cell/mobile

GENDER: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_ MARTIAL STATUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

m/f/other m/d/s/w

Is the person you are applying for a scleroderma patient? \_\_\_\_\_\_\_\_\_\_\_\_\_

yes/no

If yes, when were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_ year

Type of Scleroderma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i.e. Diffuse, Limited, Localized, etc.

Employed (if yes where): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

name of employer

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

city/state/zip

COUNTRY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

work phone number

How much do you/patient/household make in a year? Gross: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many dependents besides yourself do you claim on your taxes? \_\_\_\_\_\_\_\_\_\_(#)

Provide proof of income for the **applicant of the award**. Such as W2, pay-stub, SSI award letter (current year), SSDI award letter (current year), tax return. If you/patient are applying for assistance with durable medical equipment funds, please provide documentation of **out-of-pocket expenses/pricing quote for durable medical equipment.**

Please include copies of ALL applicable documents with the application and return to: [**scleros@SHOUTinternational.org**](mailto:scleros@SHOUTinternational.org)

**PLEASE BE ADVISED AN APPLICANT WILL ONLY RECEIVE ONE AWARD!**

**Financial Need Information: Please submit any bills or other written documentation that substantiates you/patient’s need. LACK OF DOCUMENTATION WILL RESULT IN DISQUALIFICATION.**

Amount of financial assistance you/patient are applying for? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**total**.

You/patient need the assistance by? Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_.

**There is no guarantee that the funds will be available by date requested.**

Is there any additional information you feel the Board of Directors need to consider your application? (If you need more writing space, use the back of this application, or attach another page to the application).

How did you hear about the S.H.O.U.T. International Organization?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your application will be reviewed, and you will receive an acceptance/denial in writing within \_\_\_\_\_\_\_ days.

Please include an Emergency Contact In the event that the applicant cannot be reached.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for applying,

Board of Directors

email: [scleros@SHOUTinternational.org](mailto:scleros@SHOUTinternational.org)

twitter: @SHOUTorg.

Facebook: <https://www.facebook.com/S.H.O.U.T.International/>

Disclaimer: The **S.H.O.U.T. International** organization in no way endorses any other organization that supports, funds, research scleroderma. **S.H.O.U.T. International** is a standalone nonprofit and any perceived conflict with any other organization is

coincidental and not intended to imply affiliation. Any taxes incurred because of receiving funds, from **S.H.O.U.T.** International, will be the sole responsibility of the applicant**. S.H.O.U.T. International** is not affiliated with nor does it participate in fundraising with any other non-profit organizations. It is a stand-alone organization; whose primary goal is to help patients and/or families in need of assistance**. S.H.O.U.T. International** does not discriminate against race, religion, gender, age or sexual orientation.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_agree that the above statements are truthful and not misrepresented in any way, I have never received an award from **S.H.O.U.T. International** prior to this application. I agree that the funds raised on my behalf will be spent as stated on the application above. If purchasing durable medical equipment either a written quote or paid receipt must be submitted for reimbursement. I understand that **S.H.O.U.T. International** cannot pay any vendor directly for equipment. I understand that if I am chosen to receive an award, I will not hold **S.H.O.U.T. International** responsible for direct payment of any bills. The award is designed to reimburse the patient **ONLY** for payments or purchases listed above in the application. It will be the patient’s responsibility to use **ALL** funds for which they were intended.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

Please Provide 2 Personal and 1 Professional References (That are not of any relation to the applicant)

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ first/last

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

street/city/state/zip

COUNTRY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

home/cell

RELATIONSHIP TO APPLICANT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ first/last

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street/city/state/zip

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home/cell

RELATIONSHIP TO APPLICANT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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street/city/state/zip

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home/cell

RELATIONSHIP TO APPLICANT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_