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

www.shoutInternational.org

"Everyone at Some Point Needs A Little Help to Get Back on Track"

Please fill application with correct and truthful information for candidate consideration.

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.

There will be an automatic Disqualification of ALL Applicants at any sign of FRAUD or intent to DE-FRAUD.

PLEASE BE ADVISED AN APPLICANT CAN 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? _____
yes/no

If, yes When were you diagnosed? _____ (year)

Are you applying for someone else? _____
yes/no

If yes, please fill out this section:

NAME: _____
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), 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 or proof of balance not covered by insurance. Please also include proof of address 2 bills from 2 different months (utility bill/credit card bill etc.) and proof of Scleroderma Diagnosis.

Please include copies of ALL applicable documents with the application and return to:

scleros@SHOUTinternational.org

PLEASE BE ADVISED AN APPLICANT WILL ONLY RECEIVE ONE AWARD!

Award Assistance Financial Need Information:

Please submit any bills or other written documentation that substantiates you/patient's need.

LACK OF DOCUMENTATION WILL RESULT IN DISQUALIFICATION.

What is the purpose of your/their financial request? (In detail please feel free to you the reverse side of paper)

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 the application or attach another page to the application).
_____

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

What would it mean to you/your family to receive this Award? (Use back of application/separate sheet of paper to write)

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

S.H.O.U.T. International
Nonprofit 501 (c) (3)
email: scleros@SHOUTinternational.org
twitter: @SHOUTorg.
Facebook: https://www.facebook.com/S.H.O.U.T.International/

I/we _____agree that the above statements are truthful and not misrepresented in any way, I/we have never received an award from S.H.O.U.T. International prior to this application. I/we agree that the funds raised on my/our 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/we understand that S.H.O.U.T. International cannot pay any vendor directly for equipment. I/we understand that if we are chosen to receive an award, we will not hold S.H.O.U.T. International responsible for direct payment of any bills. The award is designed to reimburse me/us for payments or purchases listed above in the application. It will be my/our responsibility to use ALL funds for which they were intended.

_____ Date: _____
Signature

_____ Date: _____
Signature

Please include two personal and one professional reference:

Name: _____
First/mi/last

ADDRESS: _____
street

ADDRESS: _____
city/state/zip

COUNTRY: _____

PHONE: _____
home cell/mobile

Relationship to patient: _____

NAME: _____
first/mi/last

ADDRESS: _____
street

ADDRESS: _____
city/state/zip

COUNTRY: _____

PHONE: _____
home cell/mobile

Relationship to Patient: _____

NAME: _____
first/mi/last

ADDRESS: _____
street

ADDRESS: _____
city/state/zip

COUNTRY: _____

PHONE: _____
home cell/mobile

Relationship to Patient: _____