COMPASSIONATE CARE FUND APPLICATION

Client Information			**Today's Date: _____/_____/_____**
First Name:	**Middle:**	**Last:**	
Home Address:	**City:**	**State:**	**Zip Code:**
Mailing Address:	**City:**	**State:**	**Zip Code:**
Home Phone #:	**Cell Phone #:**		
Date of Birth: _____/_____/_____	**Do you have insurance? (circle one) Yes No**		

Marital Status:	Single	In a relationship	Married	Divorced	Separated	Widowed

Household Size		
Name:	**Date of Birth:**	**Do They Work: Yes or No**
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

PLEASE NOTE: To comply with federal regulations, in order to give you a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Please send your yearly income tax return, copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive as proof of family income with this form. Only the family size and annual income will be used to determine your eligibility and calculate your discount.

Household Income			
Name:	**Amount**	**Frequency (Circle One)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	**$**	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support/Alimony					
Interest Income					
Other					
				Total	**$**

Sliding Fee Scale:

A - 100% Discount

B – 80% Discount

C – 60% Discount

D – 40% Discount

E – 20% Discount

F – 0% Discount

All Discounts/Scholarships Awarded and length of time awarded are dependent upon the amount in the "Compassionate Care Fund" at the time of need.

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I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Hope Meadows Foundation if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Hope Meadows Foundation. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____ Client Name (Print):_____

Client Signature: _____

Parent/Guardian Name (Print): _____

Parent Guardian Signature: _____

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