REACHING OUT FOUNDATION INC.
FINANCIAL ASSISTANCE APPLICATION

CLIENT INFORMATION (To be completed by Patient and/or Social Worker) **PLEASE PRINT**

____
Patient Name Middle Name Last Name

____
Parent Name (if under 18) Middle Name Last Name

____
Mailing Address Apartment/Unit #

____
City State Zip County

____
Home Phone Cell Phone Email:

____
Male ◯ Female ◯ Marital Status Spouses Name (if applicable)

Patient's Date of Birth ___/___/____ Patient's Age_____

____
Total # of People Living in Household # of Adults in Household # of Children in Household

DEMOGRAPHIC INFORMATION (To be completed by Patient and/or Social Worker)

Current Source of Household Income (Please check all that apply) If child is under 18, provide parent/guardian information

____ Full Time Employment ____with benefits ____Part Time Employment ____with benefits ____working spouse

____Parent Income ____Social Security ____Supplemental security income (SSI) ____Disability from Work

____Other (Please Explain)____

Work Status of Household Members (Please check all that apply)

____Currently employed PARENT / OR SELF Employer Name______________________________________

____Currently employed PARENT/ OR SPOUSE Employer Name____________________________________

____Medically Disabled ____Retired ____Unemployed Date unemployment began____________________

Current Source of Healthcare Coverage: (Please check all that apply)

Name of Insurance____ ________________________ ____Medicare Part A only____Medicare Part A and B___________Other Medicare coverage_________________________ Medicaid ____ Katie Beckett Medicaid_____COBRA ____ Not Insured ____

Annual Deductible $ _________ Annual Out of Pocket $___________________

Medical Status (Please check all that apply)

____Cystic Fibrosis ____CFRDiabetes ____Lung Transplant ____Liver Transplant ____Kidney Transplant ____Other______________

Cystic Fibrosis-Reaching Out Foundation Inc. PO Box 870747, Stone Mountain, GA 30087
Email to: susan.reachingout@gmail.com OR FAX 770-564-2331

Cystic Fibrosis
Reaching Out Foundation Inc.

FINANCIAL ASSISTANCE APPLICATION (To be completed by Patient and/or Social Worker)

Patient's Name____

(Please answer all questions for the review committee)

ASSETS:

Checking $___________
Savings $___________
Stocks and Bonds $___________
Retirement Accounts $___________
Value of Home $___________

AUTOMOBILE (S):

YEAR______MAKE______ AMT OWED$___________
YEAR______MAKE______ AMT OWED$___________

LIABILITY:

CREDIT CARDS BALANCE: $____________

Household: All people living in your home (include all children, adults, or minors, non-related household members, parents, grandchildren, siblings, renters etc.

Income: Total amount for wages or salary income, self-employment income, interests, dividends and rental income, Social Security Retirement and Social Security Disability Income, Supplemental Security Income, child support, public assistance, TANF, food stamps, family's financial help, income from working children, parents, siblings, etc who reside in your household.

Expenses: General household expenses per month- rent/mortgage, food, average utility, phone charges, basic phone, cell phone, credit card payments-monthly amounts, not total balances owed.

MONTHLY HOUSEHOLD NET INCOME

(Please read above description)

WAGES (net) $_______________
SPOUSE'S INCOME $_______________
FAMILY MEMBER'S INCOME $_______________
SOCIAL SECURITY (SSDI, SSI) $_______________
ADDITIONAL DISABILITY $_______________
PENSION $_______________
RETIREMENT INCOME $_______________
TANF $_______________
FOOD STAMPS $_______________
RENTAL INCOME $_______________
DIVIDENDS $_______________
OTHER $_______________
TOTAL MONTHLY INCOME (A) $_______________
TOTAL MONTHLY EXPENSES (B) $_______________
AMOUNT REMAINING (A – B) $_______________

If your monthly expenses are more than your monthly income, please explain how you are paying your bills each month on a separate piece of paper.

I authorize information released between the Reaching Out Foundation Inc. and my cystic fibrosis center or other related parties to verify information related to this request. I agree to be added to Reaching Out Foundation Inc. database for future mailings.

____

Applicants Signature DATE

MONTHLY HOUSEHOLD EXPENSES

(Please read above description)

____RENT ____MORTGAGE $_____________
FOOD $_____________
UTILITIES
TELEPHONE $_____________
GAS/ELECTRICITY $_____________
CELL PHONE $_____________
WATER $_____________
TRANSPORTATION
AUTO PAYMENT $_____________
GASOLINE $_____________
AUTO INSURANCE $_____________
REPAIRS $_____________
MEDICAL EXPENSES
INSURANCE PREIMUM $_____________
MEDICATIONS $_____________
HOSPITAL/DOCTORS $_____________
DENTAL $_____________
CHARGE ACCOUNTS
BANK CARDS $_____________
LOANS (Monthly payment) $_____________
CHILD CARE $
OTHER $_____________
OTHER $_____________
TOTAL EXPENSES (B) $_____________

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SOCIAL WORKER'S/ HEALTHCARE WORKER'S STATEMENT

Please PRINT: **You may type on a separate piece of paper and attach to PAGE 3**

PATIENTS NAME:____

PATIENTS/FAMILY MEMBERS EMAIL ADDRESS:____

Please check below:
_____ I have explained to the patient that funds received from the Reaching Out Foundation are from an all-volunteer organization and funds are raised by volunteers only. The funds are limited and the Foundation will evaluate the needs of the patients determining approval. I have explained that the Reaching Out Foundation is in NO WAY affiliated with the Cystic Fibrosis Foundation. ____
Signature of person completing this form

SOCIAL WORKER'S/ HEALTHCARE WORKER'S STATEMENT
Please document fully the background information creating the need and your recommendation to the patient:

I, social worker/healthcare provider, understand that the application must be completed in its entirety before submitting. Any missing information will cause delay and my request will be denied. I understand that I may reapply by submitting the ENTIRE application and completed documents again. (Total Pages 6)

Requesting Social Worker/Healthcare Provider____

Signature____

Email address:____

Phone:____

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CHECK REQUEST FORM

PATIENTS NAME:____

PATIENTS EMAIL:____

Amount Requested: $**__________________________**Amount Approved$_________________________

REASON FOR THE REQUEST: (check all that apply)

__Patient has been hospitalized/home sick and patient/or caregiver has missed ____ days from work.
__Not covered by insurance __ Lost Job __ Hours at work cut back __Pay cut __ Other

A. Does family have savings to cover for extraordinary circumstances in the future? If not, what is their plan?
____

B. What changes has the family made in their spending so they have reserves to cover this type of emergency in the future? ____

C. Has patient/family received assistance from Reaching Out Foundation in the past? ____ If so when and how much?
____

D. Has social worker referred family to consumer credit counseling? __________ If so when? ______________________

E. Reaching Out funds should be used as a last resort. What community funds have you tried before making this request?
____

F. Other information that might assist the committee when reviewing the application?
____
____

All information in this box is needed to process the payment online. The application will be denied if any of the information is missing.

MAKE CHECK PAYABLE TO: ____

ATTENTION: ____

BILLING ADDRESS: ____

CITY, STATE ZIP____

PHONE NUMBER____

ACCOUNT NAME/NUMBER____

(Checks are only made payable to the provider of service)

Note: The bill **MUST** be for the person listed on the application.

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Reaching Out Foundation Inc.

PLEASE ATTACH THE BILL FROM

THE PROVIDER OF SERVICE.

IF IT IS FOR A MEDICAL BILL, PLEASE ALSO INCLUDE A COPY OF THE EOB (explanation of benefits) or other documents that prove that this is the patient's portion.

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PATIENT NAME____

PATIENT EMAIL____

PATIENT and/or PARENT STATEMENT

__ I understand that the funds received are from the Reaching Out Foundation Inc. which is an all-volunteer organization and funds are raised by volunteers only. The funds are limited and the Foundation will evaluate the needs of patients in determining approval.

__ Attached is a photo of our family.

__ I will be happy to share how the foundation has assisted me during this time. I will share donation envelopes with my friends and family and co-workers in order to raise funds for the Reaching Out Foundation. I understand I can create my own fundraising page at RAZOO to electronically help the Foundation receive donations. I would like to learn more about it ___ YES __NO

___I GIVE MY PERMISSION FOR MY INFORMATION USED IN THIS APPLICATION TO BE USED BY THE REACHING OUT FOUNDATION INC. BOARD OF DIRECTORS AND/OR EMPLOYEES TO MAKE A DETERMINATION ON MY ELIGIBILITY.

Your signature____

In your own words, please provide information on (1) why you are making the request (2) what it means to you to receive this assistance. The donors always want to know that we are helping real people in real situations.

My STATEMENT

_1____

____

____

____

_2____

____

____

________________________________ *You may also email your statement and acknowledgement of the items above to:susan.reachingout@gmail.com*

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