MEDICAL FINANCIAL REQUEST FORM

TODAY’S DATE:

PERSON FILLING OUT APPLICATION:

CHILD’S FULL NAME: D-O-B:

MOTHERS FULL NAME:

FATHERS FULL NAME:

DOES FAMILY LIVE AT SAME ADDRESS? □YES □ NO (If no, please provide both addresses and telephone numbers.)  
ADDRESS: (Including City, State and Zip)

TELEPHONE: Home: Work:

E-MAIL ADDRESS:

INSURANCE PROVIDER (if applicable):

CHILD’S DIAGNOSIS:

Itemized Statement of Bill Funds Requested

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Biller to be Paid** | **Biller Phone Number** | **Account #** | **Date(s) of Service** | **Amount Requesting to be Paid** |
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Attach outstanding medical bills related to the applicant’s condition you would like to have paid.

Copies of bills are acceptable as long as they are legible. Please do not send original bills.

HARDSHIP LETTER

The information in the hardship letter will be used to determine approval.

Please tell us about the following in a concise manner

CHILD’S FULL NAME: D-O-B:

1. The condition of patient and prognosis.
2. Your family and other support system
3. Your hardship and need for help