THE 4-A HEALING FOUNDATION
APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name ____

Patient's Date of Birth _______________ Today's Date ____________________

I. Household Information

	Full Name(s)	Social Security Number
Parent(s) or Legal Guardian(s):	______________________________	____________________
	______________________________	____________________

Address

____

Street City State ZIP

Daytime Telephone (______)_______________ Cell Phone (_____)_______________

Email Address ____

Household Members	Age	M/F	Relevant Medical Conditions

(Attach an additional sheet if necessary)

II. Medical History

Please attach the following:

- A detailed description of your child's medical condition, including treatment history.
- A copy of an evaluation or statement by your child's physician or other clinician and/or your child's educator.

III. Financial Information

a. Income

Household Member	Name	Occupation	Employer	Monthly Income
Parent/Guardian				
Parent/Guardian				
Other Members, if any				
Other Income (i.e. social security, child support etc.)				
TOTAL Monthly Income				

b. Monthly Expenses

Expense	Description	Monthly Amount
Food	___	___
Utilities	___	___
Auto/Gas	___	___
Telephone	___	___
Clothing	___	___
Child Care	___	___
Rent/Mortgage	___	___
Insurance/Auto	___	___
Insurance/Life	___	___
Insurance/Health	___	___
Credit Card	___	___
Credit Card	___	___
Other	___	___
Total Monthly Expenses		___

c. Assets (from most recent monthly statement)

Asset	Amount
Savings Account Balance(s)	___
Checking Account Balance(s)	___
Stocks, bonds, CD, money market balance(s)	___
Other Account Balance(s)	___
TOTAL Liquid Assets	___

If you own any of the following items, please list the type and approximate value. Do not include your primary residence in this section.

Asset	Description	Value
Secondary /Vacation Home	___	___
Automobile (make/year)	___	___
Additional Vehicle(s) (make/year)	___	___
Other property (describe)	___	___
Other property (describe)	___	___
Total Other Assets		___

d. Creditors

Creditor	Description	Amount
Mortgage	___	___
Credit Cards	___	___
Medical/Doctor	___	___
Medical/Hospital	___	___
Medical/Other	___	___
Other	___	___
Total Creditors		___

TOTAL MONTHLY INCOME (from a) ____________________
LESS TOTAL MONTHLY EXPENDITURES (from b) (-) ____________________
NET DISPOSABLE INCOME (=) ____________________

Should there be any other factors or circumstances you believe should be considered, you may describe these on a separate page.

IV. Health Insurance

Please describe any current insurance plans (including Medicaid) covering the applicant.

Primary Insurance Carrier: ____________________ Policy Number: ________________

Name of Policy Holder: ____________________ Group Number: ________________

Secondary Insurance Carrier: ____________________ Policy Number: ________________

Name of Policy Holder: ____________________ Group Number: ________________

Other Insurance: Please describe on a separate page if applicable.

Please include with your application a copy of your most recent tax return and/or pay stubs.

If financial assistance is approved for the Patient, the 4-A Healing Foundation will notify you in writing.

By signing below, I acknowledge that I have read and understand the attached Terms & Conditions and I agree to abide by them.

Signature ____

Printed Name ____

Relationship to Patient ______________________________

Date ____

THE 4-A HEALING FOUNDATION
APPLICATION FOR FINANCIAL ASSISTANCE
TERMS & CONDITIONS

1. **Complete Application.** I certify that all the information contained in this application is true and complete to the best of my knowledge. I hereby authorize the 4-A Healing Foundation and its officers, directors, employees, and agents (collectively, the "Foundation") to review this application and to determine our eligibility for financial assistance. I agree to cooperate promptly and fully in any review of this application. I agree to submit any additional information requested. I agree that the Foundation may contact the creditors listed on this application, credit reporting bureaus, state and federal authorities, and others in order to verify the information provided.

2. **Reporting Changes.** Should a change in the information listed above occur during the application review period or during the grant period (if a grant is approved), I shall immediately notify the 4-A Healing Foundation in writing. Changes must be reported to:

   Financial Assistance Coordinator
   4-A Healing Foundation
   1325 Avenue of the Americas
   Suite 2800
   New York, NY 10019
   Fax: (888) 325-7450
   Email: assistance@4AHealingFoundation.org

3. **Financial Assistance Provisions**. The following provisions apply if the Foundation approves financial assistance for the Patient:

   a. Financial assistance is approved solely for the Patient and will be paid directly by the Foundation to a participating physician and/or laboratories, supplement providers or compounding pharmacies, as identified and approved by the Foundation. I understand and agree that financial assistance will not be paid to me or the Patient directly, or to other healthcare providers.

   b. The Foundation is not responsible for payment of any amount other than the specific amount of financial assistance approved by the Foundation based on this application. I acknowledge and agree that financial assistance is awarded only for a specific grant period and that additional applications and reviews will be required to be considered for additional grants.

   c. The Foundation will retain any funds that remain unspent at the end of the grant period.

4. **Compliance with Foundation Rules.** I have read and agree to abide by the Foundation's policies and procedures, including but not limited to the Patient Eligibility & Participation Requirements. I will read and keep up-to-date with these rules. I agree that I bear the burden of demonstrating and maintaining compliance during the application review period and for the duration of the grant period (if a grant is approved).

5. **Consequences of Noncompliance**. In the event of a violation of a Foundation rule or of these Terms & Conditions, the Foundation may take one or more of the following actions:

   a. refuse to approve financial assistance;
   b. withhold approved amounts;
   c. demand a refund;
   d. suspend or terminate its approval of financial assistance;
   e. declare the Patient ineligible for further financial assistance; and
   f. take other remedies that may be legally available.

6. **Waiver of Claims & Indemnification.**

   a. I hereby waive all claims against the Foundation arising out of this application and the receipt of financial assistance (if any), including but not limited to (i) claims arising out of any release of information by the Foundation to creditors, credit reporting bureaus, state and federal authorities, and others in order to verify the information provided, and (ii) claims arising out of medical treatment and related activities paid for by the Foundation.

   b. I agree to indemnify the Foundation for any third-party claims arising out of any action taken pursuant to the policies and procedures of the Foundation with regard to this application and financial assistance (if any).

   c. The provisions of this Waiver of Claims & Indemnification section do not extend to claims based on the gross negligence, willful misconduct, or intentional misconduct of the Foundation.

   d. The obligations and rights under this Waiver of Claims & Indemnification section will survive beyond the grant period and remain in full force and effect.

   e. I acknowledge that the submission of this application does not in any way bind the Foundation to provide assistance, and that the extent and amount of any assistance provided shall be at the sole discretion of the Foundation.

7. **Sole Agreement.** This document contains the entire agreement between the individuals listed on this application and the Foundation concerning financial assistance from the Foundation. This document supersedes all prior and contemporaneous oral and written understandings. No amendment of these Terms & Conditions will be valid unless in writing and signed by the Foundation and a parent or guardian of the Patient.