

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
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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 the individual's medical condition, including treatment history; and;
- a copy of an evaluation or statement by the individual's physician attesting to the individual's diagnosis.

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. Family 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)	_____
Trust(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, if owned (make/year)	_____	_____
Additional Vehicle(s) Owned (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	(=)	_____

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.

V. Your Story

Please tell us in your own words about your situation and your child’s journey so far. Feel free to tell us about the direction you would like to see your child’s treatment take as it relates to biomedical care, and include any other factors or circumstances you believe should be considered. (Approximately 250-1500 words, but a shorter or longer description is okay.)

Please include with your application a copy of your most recent tax return and/or pay stubs. The Foundation reserves the right to request other financial documents, including credit card statements.

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 _____

Please remember to include:

- A copy of your most recent tax return or pay stubs
- A detailed description of the applicant’s medical condition, including treatment history
- A copy of an evaluation or statement by the individual’s physician attesting to the individual’s diagnosis
- Your story, as described on Page 3, Section V

**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.