aTEAM MINISTRIES

Request For Financial Assistance

Patient's Name: _____ _____ ___
Last *First* *MI*

Address: _____ Apt#:_____

City: _____ State:_____ Zip:_____

Parent's Name(s): _____

Email: _____ Telephone: _____

TYPE OF ASSISSTANCE REQUESTED: (Please submit a copy of the bills with the application.)

____Utility (electricity, water or gas) ____Mortgage/Rent ____Medical Insurance Premiums

____Other, Please explain_____

A. Income:

Monthly Wages: $_____
Disability / SSI: $_____ Have you applied for disability /SSI? ___yes ___no
If no, why_____
If yes, what is the status: ____approved ____ pending
____denied ____ other:_____

Other Income: $_____
Explain: _____

Total Net Income: ***$*** _____

B. Monthly Expenses:

Rent/Mortgage Payment: $_____
Electric: $_____
Water/Trash: $_____
Auto Payment: $_____
Auto Insurance: $_____
Credit Card Payments: $_____
Food: $_____
Clothing: $_____
Other Medical Expenses: $_____
Other Expenses: (i.e. loans, $_____
cable, cell phone, etc.) $_____
Explain: _____

Total Monthly Expenses: $_____

Available Funds: **A minus B =** $_____

C. Financial Resources Available:

Checking:$_____ Money Market: $_____
Savings: $_____ Cd's, Stocks, etc: $_____
Property: $_____ Life Insurance: $_____

Total Available Liquid Assets: $_____

PROVIDER STATEMENT

(may be completed by your oncology physician, nurse or social worker)

Patient Name:_____ DOB: _____

Diagnosis: _____ Date of diagnosis:_____

Is Patient in active treatment? _____Yes _____No

If so, current treatment plan and probable duration of therapy:

_____
_____
_____
_____

_____ _____
Provider signature date

Parent's Signature _____ Date_____

Determination: _____
_____
_____

Assistance Provided: _____

_____ _____
Board Member Signature Date

_____ _____
Board Member Signature Date