**ALS Financial Assistance Application**

Patient Information: (please print clearly)

First Name: ________________________________________ Last Name: __________________________________________

Date of Birth: ___________________________ Age: __________ Male Female (circle one)

Marital Status: Single Married Separated Divorced Widowed (circle one)

Ethnicity: African American Asian Caucasian Hispanic Other (circle one)

Street Address: ___________________________________________________________________________________________

City/Town: _______________________________________ State: ______________ Zip: _________________________________

Phone Numbers: Home (______)_______________________________________
Work (______)_______________________________________
Cell (______)_______________________________________

Email Address: _______________________________________________________

If patient is a minor (under 18), name of parent or guardian: _______________________________________________________

How did you hear about the Mary Beth Benison Foundation? _______________________________________________________

Briefly explain your circumstances/case, including diagnosis and financial need: (Note: We require medical certification from treating physician. Please have your physician fill out the page of this document entitled Physician's Certification Letter. If you are working with a social worker have the Health Care Professional page completed.

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
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Mary Beth Benison Foundation * P.O. Box 160, Holden, MA 01520 * 774-275-0240
Email: mbbfoundation@gmail.com * www.mbbloves.org

**PURPOSE:**
My request is for assistance with the following expenses:

_______ Electric Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

Address: _________________________________________________________

_________________________________________________________

_______ Telephone Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

Address: _________________________________________________________

_________________________________________________________

_______ Heat (Gas/Oil) Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

Address: _________________________________________________________

_________________________________________________________

_______ Water Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

Address: _________________________________________________________

_________________________________________________________

_______ Rent/Mortgage Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

Address: _________________________________________________________

_________________________________________________________



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The Mary Beth Benison Foundation

Cont.

_______ Medical Bill or Medical Services not covered by insurance Amount Requested: _______________

Check made payable to: _____________________________________________ Account #________________

Describe Type of Care: ____________________________

Address: __________________________________________________________

__________________________________________________________

_______ Medical Equipment/Supplies Amount Requested: _______________

Check made payable to: _____________________________________________

Type of Equipment/Supplies ____________________________

Address: __________________________________________________________

__________________________________________________________

_______ Other Amount Requested: _______________

Check made payable to: _____________________________________________ Account # ____________________________

Address: __________________________________________________________

__________________________________________________________

Explanation: ______________________________________________________________________________________________

Special Instructions: ________________________________________________________________________________________

**_________ I have attached copies of the bills I would like the Mary Beth Benison Foundation Inc. to consider for assistance**

****Please attach a copy of the bill(s) or invoice for which payment is requested.** The copy must include: the name on the account, account number, a current due date, amount due, and remit to address.**



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**Physician Certification Statement:**

Patient Name: ____________________________________________________________________________

Date of Birth: ____________________________________________________________________________

Address: ________________________________________________________________________________

City/State/Zip Code: _______________________________________________________________________

Phone Number: ___________________________________________________________________________

Patient's Diagnosis: _______________________________________________________________________

Date of Diagnosis: ________________________________________________________________________

Is patient in active treatment? ________________________________________________________________

Please list any additional information: ________________________________________________________

________________________________________________________________________________________

Physician Name: __________________________________________________________________________

Hospital/Medical Facility Name: _____________________________________________________________

Address: ________________________________________________________________________________

City/State/Zip Code: _______________________________________________________________________

Phone Number: ___________________________________________________________________________

Fax Number: _____________________________________________________________________________

Physician NPI:____________________________________________________________________________

**I certify that the above listed information is accurate and current.**

Physician's Signature:_____________________________________________

Date: ____________________________________________________________



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**Social Worker/Health Care Professional Information:**

Name: ___________________________________________________________________________

Hospital/Clinic/Organization Name: _______________________________________________________

Address: _________________________________________________________________________

City/State/Zip Code: _________________________________________________________________

Phone: _______________________________________ Fax: __________________________________

Email: ____________________________________________________

Referring Professional Signature: ____________________________________ Date: ___________________

Information regarding the qualifying amount for this patient will be sent to you via email.

**Medical Information Release:**

I, ______________________________ hereby release _____________________________________ and members of

(patient name) (physician name)

his or her staff to communicate via letter or phone with the Mary Beth Benison Foundation Inc. and its representatives for the purposes of confirming that I am a patient being treated for _________________________________.

(diagnosis)

**X**_________________________________________________________________________________

(signature) (or signature of parent or guardian if minor, under 18) (date)



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