The Mary Beth Benison Foundation

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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Email: mbbfoundation@gmail.com * www.mbbloves.org

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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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Cont.

_____ Medical Bill 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 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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HOUSEHOLD FINANCIAL INFORMATION:

Number of people in household: _____

Please list all of the people in your household.

Name	**Date of Birth**	**Relationship to Patient**	**Employer/Employment** Full Time/Part Time Self- Employed Unemployed/Disabled Child/Student	**Income Per Year**
		Patient		

TOTAL ANNUAL FAMILY INCOME: $

INCOME VERIFICATION:

FAMILY INCOME SOURCES (please check all that apply):

_____ Social Security (retirement) _____ Salary _____ Pension _____ Unemployment _____ Child Support/Alimony

_____ Public Assistance _____ Short Term Disability _____ SSD (Disability) _____ SSI

_____ Family/Friends provide support _____ Other – specify _____

_____ I have attached copies of my income sources (most recent award letter, benefit statement, checks or pay stubs).

Have you applied to other agencies for assistance? _____ No _____ Yes Which ones?

_____

We strongly encourage you to seek assistance from any and all resources. Assistance from other agencies does not affect eligibility with MBBF.

I declare that the information on this application is true and correct to the best of my knowledge:
PATIENT SIGNATURE:

X_____ DATE: _____

Please print full name: _____

If Patient is a minor (under 18 years old), parent signature:

X_____ DATE:_____

Please print full name: _____

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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 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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