Michal's Hope

Patient Application for Financial, Food or Housing Assistance

_____

Name

_____

Address

_____

Date of Birth

_____

Telephone

_____

SSN

_____

Spouse's Name (or if applicant is a child give Parents or Guardian's name)

Disabled Yes or No

Date of Birth_____ Health Status

_____Dialysis Days & time_____

No. of dependents in household and ages (for transportation purposes)

Is patient in wheelchair or need assistance with walking or getting in vehicle **Y____ N____**

No of individuals in household_____ Relationship to patient_____

Other members employed? _____

ASSETS

Stocks/Bonds$_____

Bank Accounts: Checking: $_____

Savings: $_____

Home Assessed Value $ _____

Auto: Year and Make _____

LIABILITIES

Loans $_____

$_____

$_____

Other debts $_____

MONTHLY INCOME

Employer Name_____

Spouse's Employer_____

Monthly Take Home Pay.....$_____

MONTHLY EXPENSES

Rent or Mortgage $_____

Food..... $_____

Telephone.....$_____

Spouse's Monthly Pay.....$_____
Social Secrurity.....$_____

SSI/SSDI.....$_____
AFDC.....$_____
Retirement Income.....$_____
Veteran's Benefits.....$_____
Food Stamps.....$_____
Child Support.....$_____
Other _____
TOTAL MONTHLY INCOME $_____

Electricity.....$_____
Gas.....$_____

Water.....$_____
Auto Payment.....$_____
Gasoline.....$_____
Treatment Related Transportation$_____
Hospital Payments.....$_____
Patient Medications...$_____
Medical Insurance....$_____
Auto Insurance.....$_____
Loans.....$_____
Cable TV.....$_____
Credit Cards.....$_____
Other_____
TOTAL MONTHLY EXPENSES $_____

*Social Worker Name*_____
*Facility*_____
*Address*_____
*City*_____ *Zip*_____
*Phone*_____ *Fax*_____
*Email*_____

For office use only

*Date*_____ *Approved* *Denied*
Start _____ *End*_____
*Account #*_____ *Amount $*_____

*Payee*_____