



Application for Financial Assistance

This form must accompany the Consent for Release of Protected Health Information for Ally's House to provide assistance.

All applications are kept confidential. Ally's House cannot meet every request and cannot provide large gifts for medical procedures. However, some assistance is generally available for things such as transportation, housing, medication, insurance premiums and other needs. Families may be prioritized by need, but no family will be ineligible because of their income level. Ally's House reserves the right and the Applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis.

Section 1 – Patient Information

Name (First, Middle, Last)		Diagnosis		Social Security Number	
Address (Street or PO Box, City, State, Zip)				Age	Gender
Does patient have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type: Managed Care Traditional Indemnity (circle) Medicare Medicaid Insurance Company: _____ Policyholder (insured person): _____ Deductible: Individual \$ _____ Family \$ _____		Does patient have a drug plan? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Plan: _____ Approximate Length of Treatment: _____			

Section 2 – Parent/Guardian Information

MOTHER/GUARDIAN INFORMATION			
Mother's/Guardian's Name	Primary Phone: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Social Security Number
	Alternate Phone: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell	
Employment (employer and nature of work/title):	Email: _____		Gross Monthly Income \$ _____
FATHER/GUARDIAN INFORMATION			
Father's/Guardian's Name	Primary Phone: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell	Social Security Number
	Alternate Phone: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell	
Employment (employer and nature of work/title):	Email: _____		Gross Monthly Income \$ _____
HOUSEHOLD LIABILITIES/INCOME INFORMATION			
Creditor: _____ Monthly Payment: \$ _____	Creditor: _____ Monthly Payment: \$ _____	Creditor: _____ Monthly Payment: \$ _____	Total Monthly Income: \$ _____ Total Monthly Liabilities: \$ _____
Creditor: _____ Monthly Payment: \$ _____	Creditor: _____ Monthly Payment: \$ _____	Creditor: _____ Monthly Payment: \$ _____	
Creditor: _____ Monthly Payment: \$ _____	Creditor: _____ Monthly Payment: \$ _____		
Does patient or family receive assistance from other agencies? If so, list agencies and nature of assistance: _____			
How were you referred to Ally's House? <input type="checkbox"/> Social Worker/Hospital Staff <input type="checkbox"/> Website <input type="checkbox"/> Another Assisted Family <input type="checkbox"/> Other: _____			

Section 3 – Need Evaluation

Please prioritize your family's needs by numbering them 1-10. _____ Housing/Rent/Mortgage _____ Clothing/Personal Items _____ Transportation _____ Overdue bills/utilities _____ Medicine/Prescriptions _____ Insurance Premiums _____ Child Care _____ Insurance Deductible Amounts _____ Groceries/Food _____ Counseling/Guidance/Support	Comments: _____ _____ _____ _____
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Section 4 – Parent/Guardian Certification

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature and that any intentional misrepresentation of the information contained in this application will result in the loss of current and future assistance from Ally's House and may result in civil liability. The Applicant hereby releases Ally's House from any and all liability which may arise from the sharing of this information to third-parties.

Parent/Guardian Signature _____	Date _____	Relationship to patient _____
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