FINANCIAL ASSISTANCE APPLICATION

Dear Applicant:

IMPORTANT -YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help BWCFI determine if you can receive free or discounted services that can help pay for your Durable Medical Equipment (DME) expenses up to $ 500.00 USD one time only. Please complete this form in its entirety, including signature and date of completion, and submit with all requested supporting documentation by mail to the Beckwith-Wiedemann Children's Foundation Int'l (BWCFI), 309 N. Washington Street, Desloge, MO 63601 or email beckwithwiedemannfoundation@gmail.com

YOU MUST BE UNINSURED or have commercial insurance to apply. Applicant acknowledges that a good faith effort has been made to provide all information requested in the application to assist the BWCFI in determining eligibility for financial assistance.

Rules:

- You will be required to pay for service up front and submit your paid receipt including the date of the current year of the application. Both must be present.
- We will only accept applications for the current year and the service must have occurred in the same year.
- Submission can be anytime during a calendar year with a deadline to be submitted by Dec 1st of the application year. The BWCFI will then review applications and award reimbursements no later than Dec 20th.
- Applications can only be submitted by immediate family members for a BWS patient.

Checklist:

- Complete all sections of application
- Sign and date application {Parents if married, spousal signature required}
- Please submit 3 months of bank statements

Please note: The BWCFI will not be able to determine eligibility without proper documentation. Please ensure that you have assembled all the required documents. Failure to send all required documents will result in a delay reviewing your application.

All fields must be completed for application to be processed; indicate N/A on all fields that do not apply.

PATIENT INFORMATION			
Patient Name:	DOB:	Telephone number:	Family Size:

Address:	Employed: Yes or No	Employer:	Do you have State insurance? Yes or No

Responsible Party Information (If different from patient)

Guarantor Name:	DOB	Telephone Number	Family size
Current Street address:	Apt #	City/State/Zip	Marital Status
Insured/What Plan	Employed? Yes No	Have you applied for Medicaid? Yes No	Employer

Household Information

Please attach a separate sheet for additional household members, including all required documents

First & Last Name	**Relation ship**	**DOB**	**Employed**	**Full time Student**	**Gross Monthly income if 18 or over -circle all applicable forms of income and indicate total amount received from all sources, (Documentation for each required)**
	Self		Yes No	Yes No	Wages - Unemployment - WC Pension - Disability - SS Alimony/Child Support - Govt Assist
			Yes No	Yes No	Wages - Unemployment - WC Pension - Disability - SS Alimony/Child Support - Govt Assist
			Yes No	Yes No	Wages - Unemployment - WC Pension - Disability - SS Alimony/Child Support - Govt Assist
			Yes No	Yes No	Wages - Unemployment - WC Pension - Disability - SS Alimony/Child Support - Govt Assist
			Yes No	Yes No	Wages - Unemployment - WC Pension - Disability - SS Alimony/Child Support - Govt Assist

Please provide proof of gross income for all household members age 18 or over including, but not limited to: wages, social security (award letter), pension(s), annuities, unemployment/workmen's compensation, alimony/child support, government assistance, disability payments, strike benefits, scholarships/grants, dividends/interest, rental income, cash for services, etc. Bank statements are not verification/proof of income. *International students will need to submit a student visa and current school schedule. Please note: Depending on the circumstances of your application, we may require additional documents including, but not limited to: bank statements, attestation of income, supporter statement, household/medical bills, credit report(s), or other evidence to support financial need.

Household Assets

Family Member Name	Checking Account	Balance	Savings Account	Balance	Other (IRA, CD, other)	Balance
	Personal Business	$	Personal Business	$		$
	Personal Business	$	Personal Business	$		$
	Personal Business	$	Personal Business	$		$
	HSA/Flex account					
Do you have an HSA/Flex account		yes	no	$		

Household Liabilities

Expense	Monthly	Balance Due
Housing		
Electric		
Phone/Internet		
Water/Trash		
Transportation (Fuel)		
Vehicle 1		
Vehicle 2		
Vehicle 3		
Childcare		
Loans		
Medical Expenses		
Other Expenses		
Other Expenses		
Insurance		

Attach a separate sheet for additional liability information

_____ _____ _____

Print name of BWS patient **Signature of BWS patient if over 18** **Date**

_____	_____	_____
Print name Parent/Guardian	**Signature Parent/Guardian**	**Date**

_____	_____	_____
Print name Parent/Guardian	**Signature Parent/Guardian**	**Date**