Ear Research Foundation, Inc.
Application for Financial Assistance

Please fill out the following financial application and submit to the Ear Research Foundation <u>along with a letter briefly describing the patient's problem/medical complaint and the reason for the application</u>.

PATIENT INFORMATION **PLEASE PRINT**

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Alternate Phone: _____

Email: _____

PARENT / GUARDIAN / SPOUSE INFORMATION

Mother / Guardian: _____ Father / Guardian: _____

Address: _____ Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

FINANCIAL INFORMATION

Employer: _____ Employer: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Position: _____ Position: _____

HOME AND ASSETS

Gross Monthly Income: $_____ Gross Monthly Income: $_____

Checking Account: $_____ Checking Account: $_____

Savings Account: $_____ Savings Account: $_____

(Verification of income must accompany this application (such as IRS Tax Return, pay stubs or income verification from employer).

OTHER INCOME

Child Support: $_____ Pension: $_____

Commissions: $_____ Rental Income: $_____

Shared Living: $_____ Alimony: $_____

Disability: $_____ Interest: $_____

Stocks, Bonds, Annuities: $_____ Other: $_____

Does the patient have Health Insurance? If yes, please provide company name and policy number:

_____

Ear Research Foundation

AUTO (S): YEAR / MAKE / MODEL

_____ _____

_____ _____

ALLOWABLE FINANCIAL LIABILITIES / MONTHLY EXPENSES

	MONTHLY	BALANCE
House / Apartment	$ _____	$ _____
Car / Transportation	$ _____	$ _____
Medical / Dental	$ _____	$ _____
Loans (non credit card)	$ _____	$ _____
Utilities	$ _____	
Child Care	$ _____	
Insurances	$ _____	
Groceries	$ _____	
TOTAL MONTHLY EXPENSES	$ _____	BALANCE TOTAL $ _____

CERTIFICATION

I certify that the information contained in this financial review and assistance request is true to the best of my knowledge. I further understand that the Foundation may verify any of the above information and I grant my permission for such verification and agree to assist in any way requested. I understand that the Foundation reserves the right to cancel my assistance and collect full fees for services in the event of fraudulent financial status while involved with any of the programs. I understand that comparison reviews will be conducted regularly at the discretion of the Foundation.

_____ _____

Signature (Patient / Guardian) Date

Ear Research Foundation

PERSONAL FINANCIAL STATEMENT OF GUARANTOR (S)

Patient Name: _____
Last First Initial

I, _____, certify that my gross household income (before taxes) has been $ _____ for the past twelve (12) months and that there are _____ (#) people in my household.

I understand that the income information I have provided may be verified by:

The Ear Research Foundation, Inc.

I understand that in accordance with Florida Statutes 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services, is a misdemeanor in the second degree.

Guarantor: _____ Date: _____

Witness: _____ Date: _____