Application for Assistance

Section 1

Patient Information

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home phone (____) _____ Date of birth _____ Gender _____
Have your previously applied to Katie's Kause Agency? _____ Yes _____ No
Referred by _____

Section 2

Parent/Guardian Information

Name _____
Relationship to patient _____ Ethnicity _____
Address _____
City _____ State _____ Zip _____
Time at current address _____ Home phone (____) _____ Cell phone (____) _____
Employer _____ Phone (____) _____
Address _____
City _____ State _____ Zip _____
Time at current employer _____ Email address _____

Second Parent/Guardian information

Name _____
Relationship to patient _____ Ethnicity _____
Address _____
City _____ State _____ Zip _____
Time at current address _____ Home phone (____) _____ Cell phone (____) _____
Employer _____ Phone (____) _____
Address _____
City _____ State _____ Zip _____
Time at current employer _____ Email address _____

Monthly Household gross income $_____
Has your monthly household income changed significantly? __ Yes ___ No
If yes, please explain: _____
_____

Names of other members in the household	Age
_____	_____
_____	_____
_____	_____
_____	_____

Section 3

Insurance Information

Health Insurance Carrier _____

Group Number _____ Phone (____) _____

Are you currently eligible for any of the following public programs:

Medicare/Medicaid _____ Yes _____ No (circle which one)

Any other state or federal services received:_____

Section 4

Medical Provider Information

Name of Physician/Clinic treating the patient for cystic fibrosis

_____

Address _____

City _____ State _____ Zip _____

Section 5

Documentation Needed

1. Latest paystub
2. Copies of the bills for which assistance is being requested
3. Complete attached monthly income vs monthly expenses form

Section 6

Letter of Intent

Please include a brief explanation of your circumstances and what type of assistance you are applying for (i.e.: housing, transportation, medical, etc). Please provide anything we didn't cover in this application that you feel we should know. Remember, we are here to help you, not judge you or make this harder on you. We understand the stresses and if there is anything we can do to make this process easier, please don't hesitate to ask. Thank you!

By submitting this application, I, _____, hereby authorize Katie's Kause Agency to obtain my protected health information. This medical authorization hereby authorizes your medical provider and insurance carriers to speak with Katie's Kause and have access to all your medical records on your child. The authorization is obtained for this transaction only. The authorization expires when this transaction is complete.

I verify that the information provided in this application is complete and accurate. I also understand Katie's Kause reserves the right at any time and without notice to modify the assistance and discontinue any or all of the programs and related eligibility criteria at any time.

Signature_____Date _____

All information provided on this application is strictly confidential and used for the sole purpose of evaluating the need of the applicant by Katie's Kause

Katie's Kause for Cystic Fibrosis

1118 Lancaster DR NE, #393, Salem OR 97301

www.katieskause.org

email: Charlotte@katieskause.org phone 503-442-5172

Monthly Expenses VS Monthly Income

Expenses

Rent/Mortgage _____

Phone/Cell _____

Cable _____

Internet _____

Natural Gas _____

Electric _____

Garbage _____

Water/Sewer _____

Car Payments _____

Car Insurance _____

Food/Groceries _____

Prescriptions for CF Child _____

Income

Parent/Guardian 1 _____

Parent/Guardian 2 _____

Child Support _____

SSI _____

EBT/Food Stamps _____

Housing assistance _____

WIC _____

Other _____