Second Wind Lung Transplant Association, Inc.

FINANCIAL ASSISTANCE FUND PATIENT APPLICATION

Use this form for requests of $500.00 or less.

Patient's Name: Last First Middle

Address City State Zip

Date of Birth Marital Status Social Security Number

Home Telephone _____ Cell Phone_____ Temp. Phone (if any)_____

Diagnosis: _____ Email Address:_____

Name of Spouse, Caregiver, Parent or Guardian Relationship to Applicant

Number of Dependents and the Ages of Each:_____

Patient's Employer's Name

Address

Last Date of Employment (if applicable) Telephone Number

Does Patient have the following?

- Medicare Yes___ No___
- Medicaid Yes___ No___
- Insurance Yes___ No___
- Prescription Drug Coverage through your insurance Yes___ No___
- What is your co-pay? $_____

Insurance Company Name: _____

Address: _____

Policy Number: _____

Spouse's Employer's Name: _____

Spouse's Employer's Address: _____

Applicant Continue ►

MONTHLY HOUSEHOLD INCOME:

Take-Home Pay	$ _____
Disability Insurance	$ _____
Spouse's Take-Home Pay	$ _____
Other Household Members' Income	$ _____
Social Security	$ _____
Retirement	$ _____
Medicaid or SSDI	$ _____
Other Government Benefits	$_____
Other Income (child support, etc)	$ _____
Income from other Organization(s)	$ _____ Name of organization(s) _____
Rental Income	$_____
TOTAL MONTHLY INCOME	**$**_____

ASSETS:

Checking Accounts:	$ _____
Bank Accounts:	$ _____ (Itemize separately)
Savings Accounts:	$ _____
Fundraising Account(s):	$_____
Home(s) Assessed Value:	$ _____
Stocks and Bonds	$ _____ (itemize separately)
Auto Make: _____Model: _____	$ _____ (list all vehicles)
Other Real Estate:	$ _____
TOTAL ASSETS	$ _____

	TEMPORARY RESIDENCE	**PERMANENT RESIDENCE**
MONTHLY EXPENSES:		
Doctors' Fees	$_____	$_____
Hospital Fees	$ _____	$_____
Medications	$ _____ (Itemize)	$_____
Family Medications	$ _____	$_____
Food	$ _____	$_____
Rent or Mortgage	$ _____	$_____
Telephone	$ _____	$_____
Electricity/Gas/Heating Fuel	$ _____	$_____
Water/Sewer	$ _____	$_____
Heating	$_____	$_____
Taxes	$ _____	$_____
Transportation	$_____	$_____
Auto Payments	$_____	$_____
Gasoline for transportation	$ _____	$_____

Insurance:

Medical Insurance	$_____
Auto Insurance	$ _____
Life Insurance	$ _____
Charge Accounts/ Credit Cards:	$ _____
Loan Payments:	$ _____
Other:	$ _____

Total Monthly Expenses: $_____ **+** $_____ **=** _____

Applicant Continue ►

LIABILITIES:
Car Loan(s), Mortgage(s), and Other Debts $ _____ (Attach documentation)

Specific Item(s) or Assistance Needed. This must include specific amounts. A lump sum request will not be considered.

_____
_____
_____
_____
_____
_____
_____

If your request is for assistance with a medication, please provide name, dose, and frequency above.

Are you receiving assistance from any pharmaceutical company? YES_____ NO_____
Please provide names, addresses, and telephone numbers of companies and amounts of support:

Name	**Address**	**Telephone**	**Fax**	**Amount of Support**

Total Amount Being Requested: $ _____

Hospital where patient is listed or being evaluated:

The applicant understands that any financial assistance granted will be paid in the form of a check payable to the provider.

In submitting this application, the patient, parent or guardian warrants the information provided to be true and can be relied upon in considering assistance to the applicant whose signature is listed below. Any misrepresentation will constitute fraud and make the applicant ineligible for assistance.

_____
Applicant's Name **(PLEASE PRINT)**

X_____ _____
Signature of Applicant or guardian) Date

_____
Witness's Name (**PLEASE PRINT**)

X _____ _____
Witness's Signature Date