

All Souls Medical Fund Application Form

Name: _____

Date: _____

All Souls Member All Souls Regular Attender

Address: _____

Phone: (home) _____ (work) _____ (cell) _____

Email: _____

1. Briefly describe your medical and financial situation and why you are requesting assistance.

2. Have you called your creditor/service provider to explore options for delaying or assisting with payments? If yes, please explain.

3. Have you previously received financial assistance from All Souls Medical Fund? If yes, please list the amounts and the dates that assistance was provided.

4. Are you currently employed? If no, please explain.

5. Are you currently insured? If no, please explain.

6. Do you currently have a primary care doctor and dentist? If no, please explain.

7. Are there other services that you are in need of? If yes, please explain.

8. Are there any additional supports in which you are in need (Stephen's minister, prayer, social worker, doctor, dentist, etc...)?

9. Specific medical need with which you need help:

10. Amount of matching assistance requested: \$ _____. If you are unable to match a gift from the fund, please estimate how much you can provide and/or provide what you have already paid toward the bill. *Please attach a copy of a current statement which shows the account number and your name on the account.

Applicant Certification, Confidentiality Agreement and Signature

Please provide one reference who can speak about the nature of your request.

Name: _____

Phone: _____

May we contact this individual? Yes No

Have you read the All Souls Medical Fund Guidelines? Yes No

The members of the All Souls Medical Fund are committed to respecting and maintaining the confidentiality of information that you provide by adhering to privacy standards as dictated by Tennessee State Law and professional ethical principles. In most circumstances, information that you provide cannot be disclosed without your written consent. There are exceptions to confidentiality: 1) if you indicate an intention to harm yourself or someone else; 2) if emotional, financial, physical or sexual abuse is known or reasonably suspected, All Souls Medical Fund members are legally and ethically bound to report this information to the proper authorities; 3) if subpoenaed to release information by a judge during legal proceedings; 4) if you sign a written release giving authorization to provide information.

I understand that I may be contacted for addition information and possible referral information. I certify that the information reported here is true, correct and complete to the best of my knowledge. I agree to provide the documentation necessary to verify the information reported. I understand that any falsification of information may disqualify my application for the present as well as for the future.

Applicant Signature: _____ **Date:** _____

Legal Guardian (if client is under 18 years of age): _____ **Date:** _____

When completed leave in church office or mail to: 1424 Exeter Ave., Knoxville, TN 37921

Date Received:

Date Processed: