

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. Include the why and what you are requesting assistance for.

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. Do you have medical, dental, and behavioral health insurance? If no, please explain.

Note: If you have insurance, your application must include the Explanation of Benefits (EOB) for the claim that you are requesting matching funds for. The Medical Fund Team needs to see that your insurance company has processed your claim.

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

7. Are there any additional supports in which you are in need such as; Stephen's minister, prayer, social worker, doctor, dentist, etc.?

8. Amount of matching assistance requested: \$ _____.

Note: The Medical Fund provides a dollar for dollar match for medical bills you have paid (see Policy for details). Your application must include a copy of the cancelled check or your medical provider's statement indicating the paid amount or a copy of your credit card bill indicating the charge for the medical service. All documentation must include your name, account number, and date.

Applicant Certification, Confidentiality Agreement and Signature

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

Name: _____

Phone: _____

Have you read the All Souls Medical Fund Policy? 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:** _____