Cynthia Rose Foundation
Celebrating Kindness, Promoting Joy

APPLICATION FOR MEDICAL and PATIENT ASSISTANCE

DATE OF APPLICATION _____

PRIMARY APPLICANT'S INFORMATION

Name: _____ Marital Status: _____

Address:_____

City_____ State_____ Postal Code_____

Email Address: _____

Telephone: Home _____ Cellular _____

Date of Birth _____

Employer: _____Telephone: _____

Employer Address: _____

City_____ State_____ Postal Code_____

Parent or Guardian's Name (if patient is a minor)_____

Parent/Guardian Phone:_____ Email_____

Number of Dependent Children and ages _____

Annual Household Income: _____

Monthly Expenses: _____

Reason for Request for Assistance:
(Please provide an explanation of the patient's diagnosis and/or disability. Attach a separate sheet if necessary)

_____

_____

_____

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How can the Cynthia Rose Foundation help your family the most:
(Check all boxes that apply to your needs)

__ Medical Bills __ Medical Supplies __ Medications __ Insurance Bills

__ Household Bills __ Transportation __ Support Groups __ Other_____

Please tell us anything additional you would like us to know about you, your life and your situation.

_____

_____

_____

_____

I, the applicant (or Parent), understand I may be interviewed by telephone, or in person, if additional information or clarification of this application is needed. I have answered all questions to the best of my ability.

_____ _____
Signature of Applicant Signature of Parent or Guardian

Date_____

_____FOR INTERNAL USE ONLY- PLEASE DO NOT WRITE BELOW THIS LINE_____

Date Application Received_____ Date of Review _____ Member _____

Disapproved ____ Approved ____ Date _____ Approved Amount _____

Reason if disapproved _____

Service approved _____

Date letter of approval or disapproval sent to applicant _____

Referred to _____ Date Provider notified _____

Date of service _____ Date invoice paid _____

Notes:_____

_____

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