Application for Assistance

Please complete the following information. Your application will then be reviewed and a determination will be made and communicated to you. Please note, all information requested below must be provided to be considered. Applications are reviewed on a bi-weekly basis.

PATIENT INFORMATION:

Name	Date of Birth	Phone
Address, City, State, Zip	Email	Language Preference

Physician Information

Treating Physician Name	Practice Name	Phone
Diagnosis		

Income/Assets (PATIENT)

Monthly Income	Amount
Monthly Unemployment Income or other public assistance	Amount
401 K or other retirement accounts	Amount
SSDI/SSI Income	Amount
Monthly Income from other sources (ie, rental property etc)	Amount
Current Employer or last date employed	Name
Number of people in household	Number

Income/Assets (SPOUSE/SIGNFICANT OTHER, PARENT OR GUARDIAN)

Monthly Income	Amount
Current Employer or last date employed	

Patient requested amount of financial assistance $_____

Please explain the need for assistance_____

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Patient signature_____

Date_____

Please Return application to:

ATTN: **Lisa Dowd**: **1721 E. 19th Ave, Suite 300 Denver, CO 80218** or email to **hello@rockymountainbloodfund.org**

TO BE COMPLETED BY OFFICE STAFF:
Date of application received
Date of determination
Date of check request
Amount granted

Date of form: 2/2019