Foundation Hope and Life USA

Emergency Assistance Application

Please fill out all information completely. If it does not apply, write "N/A."

Confidential

*DATE: _____

*Name (***Adult applicant***): _____ (Middle): _____ (Last): _____
*Age: ____ *SS#_____ *Birth date: _____*ID#_____

*Name (***Father/Mother***): _____ (Middle): _____ (Last): _____
(Applicant information, parent, guardian, custodian, or legal representative)

*Age: ____ *SS#_____ *Birth date: _____ *ID#_____
*Address: _____ City: _____
State: _____ Zip: _____ *How long at current address: _____
*Home phone: _____ *Cell phone: _____ Work phone: _____
*E-mail: _____ Fax: _____

*Mother's Employer***(or applicant***): _____ Employer's phone: _____
Employer's address: _____
*What is your occupation: _____?
Applicant's marital status: □ Single □ Married □ Divorced □ Separated.

*Father's Employer***(or applicant***): _____ Employer's phone: _____
Employer's address: _____
*What is your occupation: _____?
Applicant's marital status: □ Single □ Married □ Divorced □ Separated.

*Patient Full Name: _____ *Diagnostic _____*Date that was diagnosed _____
(if 18 years or younger) (Bring copy of your diagnostic)
*Institution where the patient is treated: _____ Contact Phone #: _____*Contact Name: _____
*Did you apply Last Year: _____? *Person Responsible for paying Bill _____

*Additional Household Members "Family" Includes people related by birth, marriage, or adoption who live together:

Full Name	Relationship	Date of Birth	Employed (IF 18 YEARS OR OLDER)	Also apply for financial assistance.

6175 NW 153rd St, suite 224 Miami Lakes, FL 33014 Ph: 786-534-2900 / FAX: 786-536-4899 Email:info@fhlusa.org

*Income and Expenses

*Monthly Family Income:

SS / SSI / SSDI:	$ _____
Employment Wages:	_____
Pension:	_____
Unemployment:	_____
Food Stamps:	_____
Workers Comp:	_____
Short- or Long-Term Disability:	_____
Child Support:	_____
Alimony:	_____
Investments:	_____
Other income:	_____
Total Income:	$ _____

*Monthly Expenses:

Rent/Mortgage:	$ _____	Mortgage balance: $_____
Electric/ Water / Gas:	_____	
Phone (Inc. cell, cable & internet)	_____	
Car payment:	_____	Loan balance: $_____
Car insurance:	_____	Type/year of vehicle: $_____
Health/Life insurance:	_____	
Other insurance:	_____	
Food:	_____	
Medication:	_____	
Credit cards:	_____	Credit card balance: $_____
Gas (auto):	_____	
Other: _____:	_____	
Other: _____:	_____	
Other loans _____:	_____	
Total expenses:	**$ _____**	

I hereby certify that all information I have provided is accurate and my statements of need are truthful. By signing below, I authorize FHLUSA to share personal information collected about me or my family in its possession, including but not limited to name, address, and other personal and identifiable information, and the type of assistance requested or received from this organization, with vendors and other community agencies and resources in order to confirm the need for or provision of the requested assistance and/or coordinate available services and assistance. Please note that if at any time, a change in circumstance occurs; this must be communicated with the P of Programs at FHLUSA.

*Signature of Patient: _____ Date: _____
(Parent, guardian, custodian or legal guardian if under 18)

Notes: (Office Use Only)