Request for Funds—CONFIDENTIAL

1. Please fill in all of the information below, so that we may process your request as efficiently as possible.
*2. Individualized assistance with this Request Form is available. Obtain help by e-mailing your name & phone number to: sjhm@sibts.org OR by calling **858-459-3421 ext 125** and leaving a message for the Health Ministries Outreach Committee. A case worker will call you to offer needed assistance.*
3. Attach copies of all estimates and other information you wish us to consider.
4. We are unable to reimburse an applicant for treatments completed and/or bills already paid.

Name_____ Street Address_____

City_____ State_____ Zip_____ Your e-mail_____

Home#_____ Cell# _____ Work#_____

Physician/Dentist_____ Tel#_____

Hospital or Clinic_____ Date of Admission_____ Date of Discharge _____

Description of your current illness/injury and treatment._____

_____

How did you hear about us? *(check)* ☐ *Friend/Relative* ☐ *Church Staff/Clergy* ☐ *Chimes Newsletter*

☐ *Sea Breeze (Bulletin Announcements)* ☐ *Weekly e-Newsletter,* ☐ *Church Website*

☐ *At a Church Event (please specify)* _____ ☐ *Other (please specify)* _____

PATIENT INFORMATION

Sex: ☐ Female ☐ Male ☐ Non-Binary Date of Birth_____ Marital Status: ☐ Single ☐ Married

No. of dependents_____ Age(s) _____, _____, _____, _____, _____, _____

Employer_____ Are you currently able to work? ☐ YES ☐ NO

If no, how long have you been unable to work? _____ When will you return to work?_____

Do you own a home? ☐ YES ☐ NO Monthly mortgage/rent payment $_____

Other monthly expenses/obligations $_____

Monthly Family Income: Yourself $_____ Spouse/Partner$_____

Dependents $_____ Other (Specify)$_____

INSURANCE / PAYMENT INFORMATION

MEDICARE ☐ MEDI-CAL ☐ WORKER'S COMP ☐ OTHER ☐ (specify)_____

If insurance does not cover, please explain:_____

_____

Total Bill$_____ Date of Bill_____ Unpaid Balance$_____

Why is funding requested?*_____

How much do you think you could contribute to your care?_____

Signature of Applicant_____Date_____

Or Signature of responsible person _____Date_____

Please provide additional information, if available, on page 2 of this form.
Additional attachments can be provided to the case manager at a later date.

Return To: *Health Ministries, St. James by-the-Sea Episcopal Church, 743 Prospect St, La Jolla CA, 92037*

SUBMIT

ADDITIONAL INFORMATION: _____