Application for Charity Care Assistance

THE FAULK FOUNDATION

Applicant Name: Last _____ First _____ MI ____

Address: _____ Do you Rent: _____

_____ Or Own:_____

_____

Number of months as a resident at this address: _____ Phone Number: _____

Social Security Number: _____ Date of Birth of Applicant: _____

Why are you seeking assistance from the Faulk Foundation?

_____

_____

_____

Please indicate what you are seeking assistance with:

Food: _____ Bills: _____ Clothing: _____ Furniture: _____

Medicine: _____ Other (please specify) : _____

Are you a U.S. Citizen?	_____ Yes	_____ No
Do you have minor children (under 18)?	_____ Yes	_____ No
Do they live with you?	_____ Yes	_____ No
Are they your birth/legally adopted children?	_____ Yes	_____ No
Do you have medical insurance?	_____ Yes	_____ No
Are you a veteran?	_____ Yes	_____ No
Are you on disability?	_____ Yes	_____ No

If Yes, how Long? _____

FAMILY MEMBERS LIVING WITH YOU

Spouse: _____

Child: _____ Age: ____

Child: _____ Age: ____

Child: _____ Age: ____

Child: _____ Age: ____

Other: _____

Other: _____

If any of the dependents living with you are employed, please fill out the form on Page (5)

SOURCE OF INCOME:

Head of Household		**Spouse**	
Current Employer:	_____	Current Employer:	_____
Occupation:	_____	Occupation:	_____
Address:	_____	Address:	_____
Phone Number:	_____	Phone Number:	_____
Other Employers:	_____	Other Employers:	_____
Address:	_____	Address:	_____
Phone Number:	_____	Phone Number:	_____

Please list ALL employers. If additional space is required, please use the form on Page (5).

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INCOME (Monthly Amount)

	Gross	Net
Head of Household	$_____	$_____
Spouse	$_____	$_____
Dependents	$_____	$_____
Public Assistance	$_____	$_____
Food Stamps	$_____	$_____
Social Security	$_____	$_____
Unemployment	$_____	$_____
Strike Benefits	$_____	$_____
Worker's Compensation	$_____	$_____
Child Support	$_____	$_____
Military Allotments	$_____	$_____
Pensions	$_____	$_____
Income from: CD's, Rent, Dividends Interest	$_____	$_____
TOTAL	$_____	$_____

EXPENSES (Monthly Amount)

Rent/Mortgage	$_____
Homeowner's Insurance	$_____
Property Tax	$_____
Electric	$_____
Gas/Propane	$_____
Water	$_____
Telephone	$_____
Food	$_____
Car Payment	$_____
Car Insurance	$_____
Gasoline	$_____
Child Support	$_____
Child Care	$_____
Medical Cost	$_____
Pharmacy Cost	$_____
Clothing	$_____
Charge Cards (Total per month)	$_____
Loans	$_____
Medical Insurance	$_____
Life Insurance	$_____
Other: _____	$_____
TOTAL	$_____

ASSETS

Cash on Hand	$_____
Checking Account	$_____
Savings Account	$_____
IRA's	$_____
Investments Stocks/Bonds	$_____
Land/Property Other than home you live in	$_____

VEHICLES

		Estimated Value
Make/Model of Auto #1	_____	$_____
Make/Model of Auto #2	_____	$_____
Make of Motorcycle	_____	$_____
Make of Boat	_____	$_____
Recreational Vehicle	_____	$_____
Car/Vehicle Insurance		$_____

If you have no income, please explain how you have been meeting your needs:

_____

_____

_____

MEDICAL INSURANCE/BENEFITS

Insurance Company: _____

Person Covered	Source & Type	ID/Case Number	Effective Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are any members of your family unable to work due to age, illness, or injury? _____ Yes _____ No

Are any of those family members minor children (under 18)? _____ Yes _____ No

If yes, please list these illnesses: _____

Are you currently seeking treatment with a physician or hospital? _____ Yes _____ No

Are you or any member of the household pregnant? _____ Yes _____ No

MEDICAL BILLS

	Total Owed	**Monthly Payment**
Doctors:	$_____	$_____
Medicines:	$_____	$_____
Hospital:	$_____	$_____
Other:	$_____	$_____

Are you currently applying for Medicaid Benefits? _____ Yes _____ No

Are you a member of an Employer Benefit Plan? _____ Yes _____ No

Have you applied for assistance from your county hospital/indigent program? _____ Yes _____ No

Is your physician donating his/her services? _____ Yes _____ No

Is anyone assisting you with payment of your hospital bills? _____ Yes _____ No

Who is assisting you? _____

How much assistance are you receiving? _____

List any other information you feel would be helpful to us in determining your eligibility for assistance.

_____

_____

_____

_____

OTHER SUPPORTING DOCUMENTS REQUIRED

_____ Bank Statements (All Accounts)

_____ Investment Account Statements

_____ Pay Stubs (reflecting last three (3) months pay or letter from employer)

_____ Latest Federal Income Tax Return filed (all pages)

_____ Medicaid Denial (if applicable)

_____ Employer Benefit Plan Description

In order to be eligible, a completed document AND all required documents must be provided, in addition to meeting all eligibility criteria.

You **DO** have my permission to use my and/or my child's name, photographic or video image in promotion of The Faulk Foundation and its fundraising activities, newsletter, website, email, or any other promotional activities _____(initial).

I understand that the information that I submit is subject to verification by the Faulk Foundation, and hereby give the Faulk Foundation permission to obtain information necessary from, but not limited to, the following sources: banks, credit unions and other financial institutions, employers, medical providers, landlord, and other agencies such as the Department of Social Services, the Department of Labor, the Social Security and Veteran's Administration, and the Immigration and Naturalization Service. I am aware that this information will be used to determine my eligibility for charity assistance and that the falsification of information in this application may result in denial of charity care assistance. I certify that the above information is true and correct. I agree to inform the Faulk Foundation within 30 days of any changes in income, expenses, insurance status or family status.

_____ _____

Signature of Applicant Date

_____

Printed Name

If Necessary:

If any of the dependents living with you are currently employed, please provide their occupations, incomes, and how long they have been employed below.

Name:	_____	Name:	_____
Relation to Applicant:	_____	Relation to Applicant:	_____
Current Employer:	_____	Current Employer:	_____
Occupation:	_____	Occupation:	_____
Address:	_____	Address:	_____
Phone Number:	_____	Phone Number:	_____
Other Employers:	_____	Other Employers:	_____
Address:	_____	Address:	_____
Phone Number:	_____	Phone Number:	_____

Please list ALL employers. If additional space is required, please attach a separate sheet of paper.

HOW DID YOU HEAR ABOUT THE FAULK FOUNDATION?

_____

_____

Applications should be mailed to the following address:

The Faulk Foundation
6135 Northdale
Houston, TX 77087
(713) 359-6196

Applications may also be submitted via:
Email to **tff@faulkfoundation.org**
Faxed to **(281) 768-6582**