ATL Foundation

Application for Assistance – Please be as thorough as possible or the process may be delayed.

The ATL Foundation provides financial assistance to lesbians in need as a result of ill health.

Name:_____

Address:_____

City/State/Zip:_____Phone:_____

Date of Birth:_____ Age:_____ No. in Household:_____

Date of Application:_____ Email Address:_____

Nature of illness:

_____

_____

_____

How has your situation or income changed since onset of your illness or crisis?

_____

Do you qualify or receive any assistance from any of the following? (Circle all that apply.)

AFDC/Welfare Medicare Medicaid Auto Ins. Worker's Comp

Unemployment Disability SSI Foodstamps Insur./Lawsuit

Other:_____

Referring Contact or Agency:_____ Phone:_____

Verification of Illness:_____Phone:_____

Signature of Qualified Medical Provider

Please be specific:
How much assistance do you need?_____

Financial assistance will be used for_____

_____

_____

FINANCIAL DATA:

Income

Total Monthly Income $_____

Source(s) of income: _____

Expenses

Rent/Mortgage	$
Utilities	$
Communications (Phone, internet, etc.)	$
Insurance	$
Transportation	$
Debt payments	$
Other Expenses	$

Assets (List any Real Estate, Vehicles, Savings, investments, etc.) Indicate value below

1.	$
2.	$
3.	$
4.	$

Are your income and resources adequate to meet your basic needs? (such as food, shelter, clothing, medical care, etc.)	Yes	No
Do you have health insurance to cover medical needs?	Yes	No
If yes, is the premium paid by your employer?	Yes	No
Will your employer continue to pay this premium while you are unable to work?	Yes	No
Can you pay the premium if you are required to?	Yes	No
How much is your health insurance premium?	$_____	
Have you recently had to postpone medical/dental care for financial reasons?	Yes	No
In order to pay for medical expenses, have you postponed payment of other bills?	Yes	No

Please attach other pertinent information that may be helpful to our understanding of your situation and about how we may help you. You may wish to include other health care provider's names and phone numbers, historical overview of your situation, etc.

HIPAA

The ATL Foundation Board of Directors wants to consider each application for financial assistance carefully. In order to do that, we request a statement of your health condition (diagnosis) and a brief statement of your treatment type and duration from your care provider. Federal HIPAA guidelines are now in place to guard the privacy of your health records. You must request and give written consent to your healthcare provider in order for her or him to release your "PHI" (Protected Health Information) **to us** on their letterhead with their signature. This information will be used solely to help the Board make a decision regarding your request for financial assistance.

By signing this paper, you are giving your health care provider permission to release this information to the ATL Foundation Board of Directors for the application process.

_____ _____

Applicant's Signature Applicant's Name Printed

_____ _____

Street Address Applicant's Phone #: Cell #:

_____ _____ _____

City State Zip

_____ _____

Health Care Provider's Signature Health Care Provider's Name Printed

_____ _____

Name of Care Facility Phone #: Fax #:

_____ _____ _____ _____

Street Address City State Zip

_____ _____

Name of other reference (friend or relative we may contact). Phone# / Email

Thank you for providing us with this information so that we may carefully consider your individual circumstances.

Mail Application to: ATL Foundation, P.O. Box 17852, Golden, CO 80402 or
Fax Application to: Sue Boynton at 303-948-2906
Scan or print to .pdf and email to: grants@atlfoundation.org
(for ATL Board use only)

Date Application Received:_____From:_____

Reviewed by:_____

_____

Action: