



P.O. Box 237~~Brooklyn , NY 11228 (917) 496-7534

Application for Financial Assistance

All applications are kept confidential. FLMF cannot meet every request and cannot provide large gifts for medical procedures. However, some assistance is generally available for things such as transportation, housing, medication, insurance premiums and other needs. Families may be prioritized by need, but no family will be ineligible because of their income level. FLMF reserves the right and the Applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis.

Name (First,Middle,Last)	Diagnosis
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Social Security Number	Address
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Does Patient have health insurance? Yes ___ No ___	
If Yes, type : circle Managed Care Traditional Indemnity Medicare Medicaid	
Age	Gender
Insurance Company _____ Policy Holder (insured person) _____	
Deductible Individual \$ _____ Family \$ _____	

Mother's/Guardian name _____ phone _____ Social Security# _____

Employment (employer and nature of work/title) _____

Email _____ Gross Monthly Income \$ _____

Father's/Guardian name _____ phone _____ Social Security# _____

Employment (employer and nature of work/title) _____

Email _____ Gross Monthly Income \$ _____

Household Liabilities/Income Information

Creditor _____	Creditor _____	Creditor _____
Monthly Payment \$ _____	Monthly Payment \$ _____	Monthly Payment \$ _____
Creditor _____	Creditor _____	Creditor _____
Monthly Payment \$ _____	Monthly Payment \$ _____	Monthly Payment \$ _____

Total Monthly Income \$ _____ Total Monthly Liabilities \$ _____

Does Patient receive assistance from other agencies? If so, list agencies and nature of assistance : _____

How were you referred to us? Social Worker/Hospital Staff Website Another Assisted Family Other

Pleas prioritize your families needs by numbering 1 to 10

<input type="checkbox"/> Housing	<input type="checkbox"/> Overdue Bills/Utilities	Comments: _____ _____ _____
<input type="checkbox"/> Transportation for Medical Treatment	<input type="checkbox"/> Insurance Premiums	
<input type="checkbox"/> Prescriptions/Medicine	<input type="checkbox"/> Insurance Deductible Amounts	
<input type="checkbox"/> Child Care	<input type="checkbox"/> Counseling/Guidance Support	
<input type="checkbox"/> Groceries/Food	<input type="checkbox"/> Other (please explain in detail on separate sheet)	

I certify that the information provided in this application is true and correct as of the date set forth and that any intentional misrepresentation of the information contained in this application will result in the loss of current and future assistance from the Francesco Loccisano Memorial Foundation and may result in civil liability. The Applicant hereby releases The Francesco Loccisano Memorial Foundation from any and all liability which may arise from the sharing of this information to third parties.

Parent/Guardian Signature Date