

## HeartStone Foundation Applicant's Financial Information

*Our mission is to provide financial assistance to those with major medical conditions so they may concentrate on healing.*

The HeartStone Foundation keeps this application private other than sharing the information with the board.

We will only share your need, your story on our website for fundraising efforts.

Completing this application provides no guarantee that your application will receive funds from HeartStone Foundation.

### INSTRUCTIONS

**The following information MUST ALL be included with your application. Missing information will delay application processing as well as disbursement of funds.**

If you have any questions or need assistance please email: [HeartStoneFoundation@gmail.com](mailto:HeartStoneFoundation@gmail.com)

- 1) Medical condition and why the money is needed: \_\_\_\_\_  
\_\_\_\_\_
- 2) When the money will be needed: \_\_\_\_\_
- 3) You have applied for financial aid with each provider.  
***If you have not, please do so before contacting the HeartStone Foundation.***
- 4) Please include your medical bills AND number them in the order you need them paid.  
***(Please Note: The HeartStone Foundation will not disperse funds directly to the individual in need and the foundation does not guarantee that funds provided will pay bills in full.)***
- 5) Two References: page 4 and 5. A reference can include employer/boss, co-workers, or church members. References will fill out pages 4 and 5, they should indicate how they know you, and why they think you need our support. Heartstone may contact references. ***Do not include yourself or family members as references.***
- 6) Completed the HIPAA Release form: page 6  
***This form allows us to speak to your medical provider and negotiate on your behalf.***
- 7) Include your IRS Form 1040 (personal return) for the prior year.
- 8) Include a financial statement for the prior year.
- 9) Any other information you feel HeartStone needs to know.

Applicant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternate contact in case we cannot reach you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Dependant Children: \_\_\_\_\_ Age: \_\_\_\_\_

Dependant Children: \_\_\_\_\_ Age: \_\_\_\_\_

Dependant Children: \_\_\_\_\_ Age: \_\_\_\_\_

Dependant Children: \_\_\_\_\_ Age: \_\_\_\_\_

Medical coverage, if any (name of provider, whether employer or personal): \_\_\_\_\_

Monthly cost of health care: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Position: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Amount of take-home pay \$: \_\_\_\_\_ per week, bi-weekly, semi-monthly or monthly

Spouse's Employer Name: \_\_\_\_\_ Position: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Amount of take-home pay \$ \_\_\_\_\_ per week, bi-weekly, semi-monthly or monthly

**Other income:**

Social Security \$ \_\_\_\_\_ Alimony/child support \$ \_\_\_\_\_

Disability \$ \_\_\_\_\_ Pension \$ \_\_\_\_\_

Workers Compensation \$ \_\_\_\_\_ Interest &amp; dividends \$ \_\_\_\_\_

Unemployment \$ \_\_\_\_\_ Rental property \$ \_\_\_\_\_



**Assets:**

Personal residence:  Rent  Own — Value \$ \_\_\_\_\_ Mortgage balance \$ \_\_\_\_\_

Vehicles: make, model and year \_\_\_\_\_ Loan balance \_\_\_\_\_

Additional vehicles: \_\_\_\_\_

Retirement accounts in value \$ \_\_\_\_\_

Cash and savings balances: \_\_\_\_\_

Jewelry, art, coins, etc.: \_\_\_\_\_

**Debt:** Monthly mortgage payment \$ \_\_\_\_\_

Home equity loan \$ \_\_\_\_\_ and monthly payment \$ \_\_\_\_\_

Rent expense, if any \$ \_\_\_\_\_

Monthly vehicle payment or lease \$ \_\_\_\_\_

Credit card: Balance \$ \_\_\_\_\_ Monthly payment \$ \_\_\_\_\_

Credit card: Balance \$ \_\_\_\_\_ Monthly payment \$ \_\_\_\_\_

Education loans \$ \_\_\_\_\_

Medical bills \$ \_\_\_\_\_

Other loans \$ \_\_\_\_\_

***By signing below, I state that all information included herein is truthful and complete.***

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*This application is valid for 12 months at which time you would need to reapply.*

**Please email or mail your application to: HeartStone Foundation...**

**Email:** HeartStoneFoundation@gmail.com

**Mailing Address:** HeartStone Foundation • 3442 Alta Vista Avenue • Cincinnati, OH 45211

**Questions or concerns? Please email us:** HeartStoneFoundation@gmail.com



**REFERENCE #2**

**Reference must fill out this page.** A reference can include employer/boss, co-workers, or church members. Reference should indicate how they know you and why they think you need our support. Please note: HeartStone may contact references. ***Do not include yourself or family members as reference.***

Reference Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

\*Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical Information Release Form (HIPAA Release Form)

*This form allows us to speak to your medical provider and negotiate on your behalf.*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Alternate contact in case we cannot reach you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

### Release of Information

I authorize the release of information including the diagnosis, treatments, records, bills, and claims information.

This information may be released to a representative of the HeartStone Foundation.

This Release of Information will remain in effect until terminated by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **Authorization to Share My Story**

### **Release Form**

Sharing the stories of those we help enable us to reach more people to impact. We would greatly appreciate it if you would be willing to share but it's not required if you aren't comfortable. Please know that if you do choose to share no financial or doctor information will be shared. We will only use your first name and what your medical challenges are, how we helped you, and the difference we made in your healing journey.

I hereby authorize the HeartStone Foundation to share my story and photo (if provided) on the HeartStone Website, newsletter, or other marketing materials and will remain in effect until terminated by me in writing.

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_