P.O. Box 722767 • Norman, OK 73070 • (405) 733-ALLY or 877-730-ALLY

Application for Financial Assistance

This form must accompany the Consent for Release of Protected Health Information for Ally's House to provide assistance.

All applications are kept confidential. Ally's House 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. Ally's House 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.

Section 1 – Patient Information

Name (First, Middle, Last)	**Diagnosis**	**Social Security Number**

Address (Street or PO Box, City, State, Zip)	**Age**	**Gender**

Does patient have health insurance? ☐ **Yes** ☐ **No**
If yes, type: Managed Care Traditional Indemnity
(circle) Medicare Medicaid
Insurance Company: _____
Policyholder (insured person): _____
Deductible: Individual $_____ Family $_____

Does patient have a drug plan? **Yes** ☐ **No** ☐
Name of Plan: _____

Approximate Length of Treatment:
_____

Section 2 – Parent/Guardian Information

MOTHER/GUARDIAN INFORMATION

Mother's/Guardian's Name	Primary Phone: ☐ Home ☐ Cell	Social Security Number
	Alternate Phone: ☐ Home ☐ Cell	
Employment (employer and nature of work/title):	Email:	Gross Monthly Income **$**

FATHER/GUARDIAN INFORMATION

Father's/Guardian's Name	Primary Phone: ☐ Home ☐ Cell	Social Security Number
	Alternate Phone: ☐ Home ☐ Cell	
Employment (employer and nature of work/title):	Email:	Gross Monthly Income **$**

HOUSEHOLD LIABILITIES/INCOME INFORMATION

Creditor: _____ Monthly Payment: $ _____	Creditor: _____ Monthly Payment: $ _____	Creditor: _____ Monthly Payment: $ _____
Creditor: _____ Monthly Payment: $ _____	Creditor: _____ Monthly Payment: $ _____	Creditor: _____ Monthly Payment: $ _____
Creditor: _____ Monthly Payment: $ _____	Creditor: _____ Monthly Payment: $ _____	**Total Monthly Income: $** _____ **Total Monthly Liabilities: $** _____

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

How were you referred to Ally's House?
☐ Social Worker/Hospital Staff ☐ Website ☐ Another Assisted Family ☐ Other: _____

Section 3 – Need Evaluation

Please prioritize your family's needs by numbering them 1-10.

_____ Housing/Rent/Mortgage
_____ Transportation
_____ Medicine/Prescriptions
_____ Child Care
_____ Groceries/Food
_____ Clothing/Personal Items
_____ Overdue bills/utilities
_____ Insurance Premiums
_____ Insurance Deductible Amounts
_____ Counseling/Guidance/Support

Comments:
_____
_____
_____
_____
_____

Section 4 – Parent/Guardian Certification

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature and that any intentional misrepresentation of the information contained in this application will result in the loss of current and future assistance from Ally's House and may result in civil liability. The Applicant hereby releases Ally's House from any and all liability which may arise from the sharing of this informaiton to third-parties.

_____ **Parent/Guardian Signature**
_____ **Date**
_____ **Relationship to patient**