Staufer Emergency Fund

Application for Chronic, Ongoing Needs

Student _____ WIN _____

Date of Birth _____ Phone number _____

Income: Gross monthly salary (from work, work study, military, TA stipend, etc.)

Documentation from the last month is required; ex. pay stubs or bank statement showing deposits

Source of Income: $ per month

_____ _____

Other monthly income (example unemployment, VA benefits, home country sponsorship):

Source _____ $_____

Source _____ $_____

Source _____ $_____

Other family income (example: spouse)

Source _____ $_____

Total monthly income $_____

Insurance:

Do you have Medicaid?

___ Yes: name of Medicaid HMO _____

___ Yes, but out of state _____

___ Pending-application date _____

___ No

Do you have other medical insurance?

___ Yes; name of plan _____ ID number _____

Family information:

Do your parents claim you on their taxes?

___Yes ___No

Do you claim other dependents on your taxes? (ex. children, spouse)

___No ___Yes, list number and relationship:

_____

Are there other factors we should know when considering your application? (job loss, unusual medical expenses,etc.)

_____

_____

_____

_____

11/13; Reviewed 6/17, 11/18

I _____ verify the information in my application is complete and accurate. I require assistance or I would not be able to afford my recommended medical care. If I have misrepresented my financial situation in any way I will no longer be eligible for assistance. If my enrollment, insurance or financial situation changes I agree to provide this information to Sindecuse Health Center. I understand that Sindecuse Health Center reserves the right to change or modify the program. A representative from Sindecuse Health Center will contact me either by phone or secure message with a determination of my application status.

Student _____ Date _____

SHC Representative _____ Date _____

SHC Representative _____ Date _____

To be completed by SHC Representative:

Acute, Emergent Need **Ongoing Need**

Approved___ Denied ___ Pending more information _____

Assistance % granted _____ of patient responsibility up to $500 per academic year

Effective dates _____ to _____

Student notified of determination by _____ Date _____