BELIEVE
Stroke Recovery Foundation

# FINANCIAL ASSISTANCE FORM

DATE APPLICATION SUBMITTED: _____

DATE APPLICATION REVIEWED: _____

APPLICANT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: **NC** ZIP: _____

COUNTY OF RESIDENCE: _____ ARE YOU A U.S. CITIZEN? _____

CONTACT PHONE NUMBER: _____ EMAIL ADDRESS: _____

***Self-Identification Information allows BELIEVE to collect valuable statistical information. The information in NO way determines financial assistance eligibility.***

GENDER: ☐ MALE ☐ FEMALE RACE: _____

HOW DID YOU LEARN ABOUT BELIEVE? _____

MEDICAL DIAGNOSIS: TYPE OF STROKE OR BRAIN INJURY _____

DATE YOU WERE DIAGNOSED _____

WHAT HOSPITAL AND/OR OTHER MEDICAL FACILITIES HAVE YOU RECEIVED TREATMENT FOR YOUR INJURY?

PLEASE LIST NAME, TYPE OF TREATMENT AND DATES. **Example**: *ABC hospital - Inpatient rehabilitation* - Occupational and Physical Therapy - Sept. 20th 2019 - Nov. 30th 2019

| FACILITY | TREATMENT | DATES |
|---|---|---|
| FACILITY | TREATMENT | DATES |
| FACILITY | TREATMENT | DATES |
| FACILITY | TREATMENT | DATES |

SELECT ALL THAT APPLY:

- ☐ EMPLOYED
- ☐ UNEMPLOYED - RECEIVING ASSISTANCE
- ☐ UNEMPLOYED - NO FINANCIAL ASSISTANCE
- ☐ RECEIVING DISABILITY

DO YOU HAVE HEALTH INSURANCE? _____ INSURANCE PROVIDER: _____

HAVE YOU APPLIED FOR MEDICAL ASSISTANCE IN THE PAST 6 MONTHS: _____

IF YES, PLEASE EXPLAIN: _____

ARE YOU ELIGIBLE OR DO YOU CURRENTLY RECEIVE MEDICARE, MEDICAID OR OTHER GOVERNMENT ASSISTANCE? _____ TYPE OF ASSISTANCE: _____

HAVE YOU BEEN ASSISTED BY BELIEVE IN THE PAST? _____ IF YES, WHEN? _____

PLEASE INCLUDE ANY OTHER FINANCIAL ASSISTANCE RECEIVED FROM ANY OTHER AGENCIES OR INDIVIDUALS. _____

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MARITAL STATUS:

| | |
|---|---|
| | MARRIED |
| | WIDOWED |
| | DIVORCED |
| | SINGLE |

IF MARRIED, NAME OF SPOUSE: _____

SPOUSE'S EMPLOYER: _____

LAST YEAR TAX RETURN WAS FILED: _____ TOTAL NUMBER OF HOUSEHOLD MEMBERS AS LISTED ON YOUR IRS FORM 1040. _____

***YOU WILL BE REQUIRED TO PROVIDE YOUR LAST YEAR'S INCOME TAX RETURN WITH YOUR APPLICATION.***

REASON YOU ARE REQUESTING FINANCIAL ASSISTANCE FROM **BELIEVE - Stroke Recovery Foundation:** _____

DOCUMENTATION REQUIRED TO ACCOMPANY THIS APPLICATION: ***Please include copies of documents and NOT originals as they will not be returned.***

- COPY OF PROOF OF US CITIZENSHIP (US Passport, Birth Certificate, Certificate of Citizenship, etc.)
- COPY OF PROOF OF NORTH CAROLINA RESIDENCY (Valid Drivers License, Utility Bill, Voter Registration, etc.)
- COPY OF MOST RECENT INCOME TAX RETURN
- COPY OF MOST RECENT MEDICAL INSURANCE EXPLANATION OF BENEFITS
- MEDICAL PHYSICIAN OR THERAPIST REFERRAL LETTER FOR CONTINUED NEED OF PHYSICAL, OCCUPATIONAL AND/OR SPEECH THERAPY

ONCE YOUR APPLICATION HAS BEEN REVIEWED YOU MAY BE CALLED FOR AN INTERVIEW BEFORE A FINAL DECISION IS MADE.

**DISCLAIMER:**

**I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE USED TO DETERMINE FINANCIAL SUPPORT ELIGIBILITY FROM BELIEVE - Stroke Recovery Foundation. ALL INFORMATION WILL BE KEPT CONFIDENTIAL. I UNDERSTAND THAT THE DOCUMENTS I SEND TO PROVE MY ELIGIBILITY MAY NOT BE RETURNED. I FURTHER UNDERSTAND THAT THE INFORMATION I AM SUBMITTING IS SUBJECT TO VERIFICATION BY BELIEVE - Stroke Recovery Foundation. I UNDERSTAND IF ANY INFORMATION PROVIDED IS DETERMIND TO BE FALSE OR INCOMPLETE, IT CAN RESULT IN AUTOMATIC DISQUALIFICATION FOR FINANCIAL ASSISTANCE. ALL CLIENT INFORMATION IS KEPT CONFIDENTIAL AND ALLOWS BELIEVE - Stroke Recovery Foundation TO COLLECT AND MAINTAIN ACCURATE DATA FOR STATISTICAL AND ACCOUNTABILITY PURPOSES.**

MY SIGNATURE AUTHORIZES BELIEVE - Stroke Recovery Foundation TO VERIFY ALL INFORMATION PROVIDED ON THIS FORM. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HAVE ALSO READ AND CAREFULLY UNDERSTAND BOTH THE DISCLAIMER AND PURPOSE OF BELIEVE - Stroke Recovery Foundation MAINTAINING MY INFORMATION IN A CONFIDENTIAL MANNER.

APPLICANT SIGNATURE: _____ DATE: _____

***If applicant requires assistance with application please provide name of person filling out application, relationship and contact number:***

PRINT NAME AND SIGNATURE OF PERSON FILLING OUT FORM ON BEHALF OF APPLICANT: _____

RELATIONSHIP TO APPLICANT: _____ CONTACT NUMBER: _____

**If you are unable to complete this application and do not have help, you may contact us directly for assistance. Please call 919-916-5200.**

*Thank you for your interest in **BELIEVE - Stroke Recovery Foundation.***

We will be in touch regarding your application as soon as possible. Until then, we wish you the best in your journey to recovery!