APPLICATION FOR FINANCIAL ASSISTANCE

Date of Application _____

Date of Diagnosis _____

Name _____ Age _____

Address _____

Phone _____ Date of Birth _____

Cell Phone _____

Email Address _____

US Citizen _____ Yes _____ No _____ Male _____ Female

If Minor:

Parents Name _____

Address _____

Phone _____ Date of Birth _____

Cell Phone _____

Email Address _____

Medical Insurance Carrier _____

Policy Number _____

Group Number _____

Address _____

Telephone _____

Medicare/Social Security Number _____

This application shall be accompanied by a separate medical report by a licensed Doctor of Medicine indicating the diagnosis and the date of diagnosis. All subject matter herein contained shall be considered confidential. I hereby give my permission for The Youth Diabetes Foundation of America to contact my medical care providers for information regarding my diagnosis, treatment, and account status.

Signature of Applicant _____

FINANCIAL STATEMENT

All sections of this page must be completed. Attach a copy of the Federal Income Tax Form (pages 1 and 2 only). Social Security Numbers should be blacked out.

Annual Family Gross Income:	
If living with parents	
Father	
Mother	
Self	
Other (rents, interest, dividends)	
TOTAL	$0.00
If living independent of parents	
Self	
Spouse	
Other (rents, interest, dividends)	
TOTAL	$0.00

Annual Family Expenses per year. List your family's expenses if living with them. If living independently, list your own. Do not include state or federal taxes.	
Mortgage / Rent	
Property Taxes	
Utilities	
Food	
Clothing	
Auto Expenses	
Medical / Dental	
Contributions	
Entertainment	
Travel	
Other	
Total	$0.00

You may provide on a separate sheet attached to this application other financial information not listed above which may be helpful in evaluating your application. This may include indebtedness due to illness, aid to grandparents, or other siblings.

Essay

In 500 words or less, please write an essay giving the reasons why you should receive financial assistance from The Youth Diabetes Foundation of America.

Eligibility

- Must 25 years of age or younger
- Must be Type 1 Diabetic
- Must be financially unable to pay for your medical bills/ prescriptions
- Must be a US Citizen

- All expenses are directly paid to the medical provider
- No monies will be directly given to a recipient