

# Foundation for Social Equity

## Medical Application

### Personal Information (Type or print)

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_ Email address \_\_\_\_\_

### Medical Information

Doctor's Name \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_

Doctor's Address  
\_\_\_\_\_

### Medical Need

What is your medical need? (use separate sheet if needed) \_\_\_\_\_

What amount are you requesting from the foundation for Social Equity for your medical need?

Attach supporting documentation for the amount requested. (for example: hospital and/or doctor bills, invoice for a medical appliance)

### Financial Information

Are you receiving financial assistance from any other organization(s)? \_\_\_\_\_

If yes, from whom and what amount(s).

Are you receiving or eligible to receive any monies from health insurance or public service?

If yes, what has it covered? (use separate sheet if necessary)

I affirm that the information provided on and with this application is true, to the best of my knowledge. I also understand that the Foundation for Social Equity may request an affidavit from my doctor, and that a separate request form would be sent for my signature.

Signature \_\_\_\_\_ Date \_\_\_\_\_