Ophoenix Application for Assistance

Please fill out the following form completely so that we may process your application as quickly as possible.

Date: _____

Name of applicant: _____

Birth Date: _____

Home Address: _____

_____

_____

Contact Info:

Home Phone _____

Cell _____

Email address _____

Other _____

Name and location of hospital or facility (if currently being treated): _____

○ Inpatient ○ Outpatient ○ N/A

Family/Caregiver Contact Info:

Name _____

Home Phone _____

Cell _____

Email address _____

Other _____

Please attach additional sheets for any lengthy answers to the questions below.

1643 Saint Francis Way, San Carlos, CA 94070
650 598-9381 www.Ophoenix.org

1. Please describe, in detail, the applicant's disability:

2. When did the applicant become disabled? _____

3. List the applicant's financial resources/sources of income (disability, retirement, etc.):

   a. _____
   b. _____
   c. _____
   d. _____

4. Description of items needed:

   a. item: _____ date needed:_____
      why needed: _____ cost :_____
   b. item: _____ date needed:_____
      why needed: _____ cost :_____
   c. item: _____ date needed:_____
      why needed: _____ cost :_____
   d. item: _____ date needed:_____
      why needed: _____ cost :_____

1643 Saint Francis Way, San Carlos, CA 94070
650 598-9381 www.Ophoenix.org

5. Have the applicant filed for any state, federal, or other programs for assistance?

○ Yes ○ No

If yes, then please list in the space below:

What was the outcome of these applications?

For each, please specify (○ Approved, ○ Pending, or ○ Denied) and give details about the status in the space below:

The above information is true to the best of my knowledge.

Signature: _____ Date signed: _____

Signed by: _____ (please print)

Relation of signer to patient:

○ Self ○ Spouse ○ Parent ○ Caregiver ○ Other

Name and contact info of person completing this form:

Name: _____

Phone: _____

Email: _____

1643 Saint Francis Way, San Carlos, CA 94070
650 598-9381 www.Ophoenix.org