



# Trinity's Treasure

Trinity Ewert Foundation

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## Application for Financial Assistance

PATIENT INFO	TO BE COMPLETED BY DR/CASE WORKER
Name: _____ DOB: _____ Age: _____ Hospital: _____ Homecare? ( ) Yes ( ) No	Diagnosis: _____ Date of Diagnosis: _____ In Active Treatment? ( ) Yes ( ) No Type of Treatment: _____ MD Name: _____
<b>PARENT/GUARDIAN INFO</b> Name: _____ Address: _____ _____ Phone: _____ Alt Phone: _____ Email: _____	Hospital / Clinic: _____ Phone: _____ Fax: _____ Email: _____ Relationship to Patient: ( ) Doctor ( ) Nurse ( ) Case/Social Worker Your Name: _____ Phone: _____
<b>FINANCIAL INFO</b>	
Currently Employed? ( ) Yes ( ) No Place of Employment: _____ Contact Name: _____ Contact Phone: _____ <i>Income Sources:</i> ( ) Salary ( ) Hourly Wage ( ) Alimony ( ) Short Term Disability ( ) Sick Leave Pay ( ) Vacation Pay ( ) Other _____ Total Household Monthly Income: _____	<i>Estimated Monthly Expenses</i> Rent/Mortgage: \$ _____ Utilities: \$ _____ Medical Bills: \$ _____ Food: \$ _____ Gas: \$ _____ Other Debt: \$ _____ Total Monthly Expenses: \$ _____

This information is confidential. Please fax this form along with copies of your outstanding bills to 619-599-8270 or email to [info@trinityewertfoundation.org](mailto:info@trinityewertfoundation.org). Our foundation will contact you shortly. Funds are based on availability.