



Trinity's Treasure

Trinity Ewert Foundation

(310) 809-8546

Fax (619) 599-8270

www.trinityewertfoundation.org
info@trinityewertfoundation.org

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: _____ Hospital / Clinic: _____ Phone: _____ Fax: _____ Email: _____ Relationship to Patient: () Doctor () Nurse () Case/Social Worker Your Name: _____ Phone: _____
PARENT/GUARDIAN INFO	
Name: _____ Address: _____ _____ Phone: _____ Alt Phone: _____ Email: _____	
FINANCIAL INFO	
Currently Employed? () Yes () No Place of Employment: _____ Contact Name: _____ Contact Phone: _____ Income Sources: () 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. Our foundation will contact you shortly. Funds are based on availability.