To What Extent Do the Following Cover the Medical Expenses of Applicant			
Services to be Covered	**Inpatient**	**Outpatient**	**Medications**
Medicare			
Medicaid (public assist)			
Employer Insurance **Name of Ins. Co:**			
Major Medical **Name of Ins. Co:**			
Private Insurance **Name of Co:**			

Medications: _____

Summary of Monthly Income and Expenses			
Source of Income	**Amount**	**Source of Expenses**	**Amount**
Salary of Legal Guardian	**$**	**Mortgage or Rent**	**$**
Salary of Spouse	**$**	**Food**	**$**
Salary of other individuals at Home	**$**	**Utilities (gas, electric, water, trash, cable)**	**$**
Social Security	**$**	**Insurance Premiums**	**$**
Social Security Disablity	**$**	**Property Taxes**	**$**
Social Security SSI	**$**	**Avg. Month Medical Costs (past 6 months)**	**$**
Unemployment Compensation	**$**	**Other-Specify:**	**$**
Pension	**$**	**Other-Specify:**	**$**
Income from interest and investments	**$**		**$**
Other-Specify:	**$**		**$**
Total Income:	**$**	**Total Expenses:**	**$**

Certification

To the best of my/our knowledge, the information supplied in this packet is correct and updated. If all the information is not correct, the application will automatically be rejected.

Type/Print Name: _____
(Legal Guardian(s)

Signature: _____ **Date**: _____

All Financial Assistance applications submitted are the sole property of The Hope Foundation of the Mahoning Valley and are kept Confidential.

Return this packet to: Attn: Grants Committee, Hope Foundation of the Mahoning Valley, PO Box 733, Youngstown, Ohio 44501

HIPAA AUTHORIZATION FORM

Applicant's Full Name | **Applicant's Social Security Number**

Address | **Applicant's Date of Birth**

City, State Zip Code | **Applicant's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   The Hope Foundation Physician Advisory Board

3. The specific information that should be disclosed is:

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying The Hope Foundation in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for the application process of The Hope Foundation.
7. This authorization expires on _____, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

_____	_____	_____
Signature of Guardian	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Log #**