SUN DEVIL FAMILY CHARITIES

SDFC CARES

PATIENT FINANCIAL ASSISTANCE FORM

FOR SDFC USE ONLY

SDFC Care #

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The SDFC Cares program provides financial assistance to members of the ASU Family facing financial hardship due to a serious health or medical condition occurring within the last twelve months. All requests are considered, however, every effort should be made to secure available community resources and exhaust other funding sources first. Completion of this online application, verification of ASU affiliation and submission of receipts are required. There is a lifetime maximum of $1500 that can be received by any individual or family. Eligibility is limited to ASU students, alumni, current employees and their immediate families.

Last Name: ____________________ **First Name**: __________________________ **Date**: _________________________

Street Address: ____ **City/State/Zip**:___ ______________________________

Phone: Home (   ) _______________________ **Work**: (   ) ______________________________________

Email:____

Age: ______ ☐ **Male** ☐**Female**

Ethnicity: ☐ **African American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Native American** ☐ **Other**

If patient is a minor, name of parent or guardian: ____

Financial Information

Currently Employed? ☐ **Yes** ☐ **No** **Number in household**: _______

TOTAL Monthly Family Income from All Sources: _________ **TOTAL Monthly Expenses:** ___________

Amount Requested*: __________

**There is a lifetime maximum of $1500 that can be received by any individual or family*

Please describe your physical health condition and specific need in detail (Add additional sheets if needed):

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Application continued on Page 2

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Health Insurance Information

Do you have health insurance? ☐ **Yes** ☐ **No** **Are prescription drugs covered?** ☐ **Yes** ☐ **No**

If yes, please indicate type of insurance: (check all that apply)
☐ **AHCCCS** ☐ **ALTCS** ☐ **Other**_______________________________
☐ **Medicare** ☐ **VA**
☐ **Private insurance** ☐ **AHCCCS pending**

Financial Assistance Requested: (Check All That Apply – DOCUMENTATION/RECEIPTS REQUIRED)
☐ **Healthcare visits, Hospital stays** ☐ **Labs/X-Rays** ☐ **Insurance co-pays**
☐ **Medications** ☐ **Non-medical home care** ☐ **Rent/Mortgage payments**
☐ **Utility payments** ☐ **Other** ____

Arizona State University Affiliation: (Check All That Apply – DOCUMENTATION/RECEIPTS REQUIRED)
☐ **Student** (For validation contact the Registrar's Office, Records & Enrollment Services at 480-965-3124)
☐ **Alumni** (For validation contact the Registrar's Office, Records & Enrollment Services at 480-965-3124)
☐ **Current Employee** (For validation contact the Office of Human Resources, at 480-965-2701)
☐ **Retired Employee** (For validation contact the Office of Human Resources, at 480-993-0008)
☐ **Immediate family** (Describe): ____

Signature____________________________________ **Print Name**____

Referred By:____ **Phone:**________________________

How did you hear about Sun Devil Family Charities?
☐ Social Worker ☐ Health Care Worker ☐ Internet ☐ Newspaper
☐ Radio ☐ Other ____

The Patient Services Committee will review this application and forward recommendations to the Board. Awards will be based on alignment with our mission and available funds. All information is for Sun Devil Family Charity use only.

Email Application: patientservices@sundevilfamily.org

-or-

Mail to: **Sun Devil Family Charities**
Attn: Robert Gramhill
One East Washington Street, Suite 1400
Phoenix, AZ 85004

Additional resources are available at "Arizona 211 Community Information and Referral Services" by dialing 2-1-1 within Arizona, or 1-877-211-8661, or www.cir.org