



SUN DEVIL FAMILY CHARITIES
SDFC CARES
PATIENT FINANCIAL ASSISTANCE FORM

<p><u>FOR SDFC USE ONLY</u></p> <p>SDFC Care #</p> <p>_____</p>
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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):

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: Gary Weeman
12628 S. 34th Street
Phoenix, AZ 85044

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