H.O.W. USE ONLY		
Date: _____	Amount Approved: $_____	Approved by: _____

Glenda M. Wright Angel Fund
Patient Application for Financial Support

1. Applicant Information

Date: _____	Date of Birth: _____
Name (First, Middle, Last): _____	
Address: _____	
City, State, Zip Code: _____	Phone: _____ Email: _____

Do you have limited English proficiency or prefer to communicate in a language other than English? ☐ Yes ☐ No
If yes, preferred language: _____ Interpreter or translated materials needed? ☐ Yes ☐ No

2. Health Coverage

Health Insurance: ☐ Yes ☐ No Medicare: ☐ Yes ☐ No Medicaid: ☐ Yes ☐ No ☐ Pending ☐ Denied
Other coverage: _____

3. Household Income and Expenses

Monthly Household Income	Amount
Applicant Take-Home Pay	$ _____
Spouse/Partner Take-Home Pay	$ _____
Social Security/Disability	$ _____
Other Household Income	$ _____
Number of People in Household	#_____
TOTAL MONTHLY INCOME	$ _____

Monthly Essential Expenses	Amount
Housing (Rent/Mortgage)	$ _____
Utilities	$ _____
Food	$ _____
Transportation	$ _____
Medical/Insurance/Prescriptions	$ _____
Other Essential Expenses	$ _____

Monthly Essential Expenses	Amount
TOTAL MONTHLY EXPENSES	$ _____

4. Assistance Requested

Check all that apply:

☐ Medications ☐ Food/Nutritional Support ☐ Utilities ☐ Transportation ☐ Medical Equipment

☐ Medical Services ☐ Rent/Mortgage ☐ Other: _____

Please describe the assistance needed: _____

_____

Total amount requested from H.O.W.: $_____

H.O.W. makes approved payments directly to vendors or service providers. Funds cannot be paid directly to the applicant. Attach invoices, bills, statements, or other documentation showing the expense.

5. Vendor/Payment Information

Vendor/Payee/Address	Account #	Phone	Amount
			$
			$
			$
			$

6. Explanation of Financial Need

To be completed by the social worker, patient navigator, or other authorized healthcare professionals.

Describe the circumstances creating the financial hardship and why the requested assistance is needed:

_____

_____

_____

7. Medical Eligibility Verification

To be completed by the physician, APRN, or other authorized healthcare professionals.

Relevant medical information needed to verify eligibility (please provide only what is necessary):

_____

_____

_____

Required attachment: Completed Patient Authorization for Disclosure of Protected Health Information form.

8. Applicant Certification

I certify that the information I have provided is true and complete to the best of my knowledge.

Applicant Signature: _____	Date: _____
Printed Name: _____	Phone: _____

9. Professional Verification

Physician/APRN Signature: _____	**Social Worker/Patient Navigator Signature:** _____
Printed Name: _____	Printed Name: _____
Phone:_____	Phone: _____
Email: _____	Email: _____
Facility: _____	Facility: _____
Address: _____	City, State, Zip Code: _____

Submission Checklist

☐ Completed application ☐ Vendor invoice, bill, statement, or supporting documentation

☐ Required healthcare professional verification

☐ Signed Patient Authorization for Disclosure of Protected Health Information

Submission Information

Jennifer McGrath, Executive Director
H.O.W. (Hearing the Ovarian Cancer Whisper, Inc.)
PO Box 3504
Jupiter, FL 33469

P: **(561) 262-6343** **F:** **(561) 246-4053**
E: **Jennifer@howflorida.org** **W:** **howflorida.org**

Submission of an application does not guarantee funding. H.O.W. reviews completed applications based on eligibility requirements, available funding, and supporting documentation. H.O.W. may contact the applicant, healthcare provider, social worker, or vendor if additional information is required.