Assistance in Healthcare
SOUTHEASTERN

600 Celebrate Life Parkway, Newnan GA 30265
Fax: 770-400-6916
saihnewnan@gmail.com

Please read carefully prior to completing application:

- *Only patients currently receiving active cancer treatment will be considered for assistance.*
- *Please complete the application in full and return by the 10th of each month.*
- *Applications received after the 10th will be considered for the next month provided you are in active treatment.*
- *Incomplete applications will not be considered.*

Date: _____

Patient's Name: _____ Age: _____

Patient's Phone Number: _____

Patient's Address: _____

City: _____State:_____Zip:_____

Are you currently in active treatment? ☐ Yes ☐ No If yes, please list last date of treatment _____

If you are in active treatment (i.e. chemo and/or radiation) please list the date of your next scheduled treatment _____

If yes, list name of treatment facility _____

Number of adults living in household: _____ Ages of dependent children in household: _____

Others financially dependent on applicant: _____

Is the patient currently employed: ☐ Yes ☐ No

Employment Status: ☐ Full-time ☐ Part-time ☐ FMLA/Disability

1. Applicant Employer:_____
   Job Title/Position: _____

2. Spouse Employer: _____
   Job Title/Position: _____

3. Other Persons: _____
   Job Title/Position: _____

Assistance in Healthcare
SOUTHEASTERN

SOURCES OF INCOME (List MONTHLY amounts):

	APPLICANT	SPOUSE	OTHER PERSONS
Net Wages (after taxes)			
Unemployment			
Sick Pay			
Social Security			
Short/Long term disability			
Retirement Benefits			
Rental Income			
Interest Income			
Alimony			
Child Support			
Trust Funds			
Room/Board			
Welfare			
Military Benefits			
Other			
TOTAL			

EXPENSES (List MONTHLY amounts):

	APPLICANT	SPOUSE	OTHER PERSONS
Rent or Mortgage			
Home Heating (non-electric)			
Electric			
Water, Sewer and Trash			
Home Phone & Cell			
Car Payments			
Car Insurance			
Gasoline			
Food			
Health Insurance			
Life Insurance			
Child Care			
Internet & Cable			

Assistance in Healthcare
SOUTHEASTERN

TOTAL			

OTHER DEBITS (i.e., credit cards, loans). LIST FULL BALANCES:

_____

_____

_____

_____

Is the patient willing to authorize SAIH to receive a credit report? ☐ Yes ☐ No

Is the patient currently on Medicare? ☐ Yes ☐ No

Requesting assistance for: *(List non-medical expenses only)*

_____

_____

_____

Is the patient or applicant willing to share their story about how Southeastern Assistance in Healthcare, Inc. has made their journey with cancer easier? ☐ Yes ☐ No

Authorization for AIH marketing approval: _____/_____
Signature Date

Note: Southeastern Assistance in Healthcare cannot assist with payment of hospital bills, physician bills, or medication.

By my signature, I certify that all information provided is voluntary, complete and accurate to the best of my knowledge. I hereby authorize the Application Review Committee representing Southeastern Assistance In Healthcare, Inc. (SAIH) to receive and review this application which includes general health information. I understand that SAIH is not required to render any assistance to me, and that I will remain responsible for payment of all bills. By accepting this application, SAIH has assumed no responsibility for payment of any bills.

_____ _____
Applicant's Signature Date

FOR INTERNAL USE:

Date application received: _____ Received by: _____

Month reviewed by SAIH committee: _____