FOP Health + Care Ministry ASSISTANCE APPLICATION

PLEASE PRINT AND SEE TERMS/CONDITIONS BEFORE SIGNING!

Todays Date: _____

Applicant Name:

Last: _____. First: _____. IN_____

Address: _____

City: _____. State_____. Zip Code: _____

Contact:
Email: _____. Cell: _____. Home:_____
Please inform on a secure (confidential) way to be contacted: _____.

1. What assistance relief are you applying for? Medical Bill ○ Rent/Utilities/Misc ○
   * If Medical bill or Rent/Utilities bill , Please attached for consideration. If Misc, please attached reason and all supporting documents for consideration.
2. Please list the account number for the bill you want to be considered: _____.
3. Were you an Ohio resident at the time of service? Yes ○ No ○
4. Are you a legal USA citizen ? Yes ○ No ○ **NOTE: YOU MUST BE A LEAGAL USA CITIZEN FOR CONSIDERATION BY FEDERAL LAW REQUIRMENTS.**
5. Have you contacted the bill requestor to negotiate a payment plan? Yes ○ No ○
6. If "Yes", are you set up on a payment arrangement? Yes ○ No ○

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Disclaimer:
The FOP Health * Care Ministry is a non- profit Christian organization, consideration of all applications submitted is not guarantee of approval of service or payment. **Applicants considered for relief services will be reviewed on a case per case basis based.** The FOP Health + Care Ministry allocations are considered based on available fund and need/eligibility and qualified services. The FOP Health + Care Ministry retains the right to deny consideration/ application review service (see terms and conditions). The FOP Health + Care Ministry **will not consider any elective/ cosmetic and or (but not limited) service(s)/requested & applications submission (see attached terms and condition)**. The FOP Health + Care Ministry will not be responsible for any/associated/applied, fees, personal, direct, indirect, legal, non-legal, affiliated , non-affiliated(but not limited to) in any relation. The FOP Health + Care Ministry (if approved) will inform of amounts approved, and will contact the applicant per their requested communication, **NOTE:** If the applicant can not be reached by the requested communication, **only one attempt will be made via the requested communication informing of the approval or denial.** If there is a balance still owed on the applicants' account; it will be the applicants sole responsibility to settle any/all balance /fees /legal /admin /direct /indirect or cost owed with the bill collector/debt that may have incurred before/after the services. The applicant can only be considered once per calendar year from which the service incurred or date of submission or approval. . Applicants that complete this application, gives full authorization to FOP Health + Care Ministry to review/research all attached documents for consideration. Applicants must have a qualified financial need at the time of submission (see terms & conditions). Due to the high volume of submission, If additional information/documents are not included at the time of submission, the applicant application will be voided as " non- qualified" and shredded with no other follow up. All additional information requests below would need to be submitted at the time of submission for consideration.

1. Itemized bill of the applicant. **(MUST BE IN THE APPLICATANT/REQUESTOR NAME)**
2. Signed application, signed terms/conditions.
3. Reason for assistance.
3. Must be a legal US citizen/resident with a current valid State ID/Driver's License or Passport **(NOTE: Passport cannot be within six (6) months of expiration.**

Applicants Signature: _____. Date: _____

INTERNAL USE ONLY:

REP:_____
DATE OF REVIEW: _____
Comments:
_____
_____
_____
_____
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