Family Diabetes Resource Center

Application for Financial Aid

_____

This form must be completed and signed in order to receive financial assistance for diabetes related expenses offered by Family Diabetes Resource Center.
Financial Aid Applicants are notified of award in advance of the program by phone or regular mail.

_____

Name_____ Date of Birth _____

Address _____

Own or Rent (please circle)----

(Please provide a copy of the lease with this application)

Name of parent or guardian _____(if applicable)

Home phone _____ Cell phone _____ Work phone _____

Name and relationship of person completing this form _____
_____
_____

The following information must be completed in full:

The FDRC is not associated with any national diabetes organization and has limited financial aid resources. Therefore to ensure coverage for all in need, we must take into account the income of all individuals living in the household including step-parents.

Please submit w-2's from all working persons living in household.

Name *Place of Employment* *Position*

Mother _____

Father _____

Step- Parent _____

Step-Parent
_____

Foster Parent _____

Custodial Grandparent _____

Number of people living in household in which diabetic resides _____

Name *Relationship* *Age*

_____

_____

_____

_____

_____

Monthly Family Income- Total for all living in the household.

Salaries and Wages *$*_____

Other sources of income (disability, social security, retirement, unemployment, child support) *$*_____

*$*_____

$ _____

$ _____

Provide diagnostic proof for person living with diabetes, or Doctors letter stating name and the diagnosis for

Type I Diabetes or Type 2 Diabetes

Please answer the following questions.

Is person living with Diabetes a child?
If so please list birth date._____
Is household eligible for food stamps? ___ Yes ___ No
If yes, number _____. Have you applied? ___ Yes ___ No
(If denied, please include denial letter.)
Does person living with diabetes have health insurance?____Yes_____NO
Is person eligible for Medicaid, or Chips? ___ Yes ___ No
Has person applied? _____
Medicaid number (required) _____
Chips number (required) _____
If denied, please include denial letter.

Leave signature Date

_____ _____

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