

INSTRUCTIONS
Medical Contingency Fund
Referral Form and Application Form

REFERRAL FORM:

Please print the requested information on the form. Sign the **Referral Form** and take it to your Physician to provide category of procedure and the information requested in the check boxes and to sign in the appropriate space.

APPLICATION FORM:

Complete the information requested at the top of page 1. Enter the names of all individuals that live in the household, their relationship and age in the boxes provided. If there are more individuals than space allotted, enter those names, relationships and ages on the back of the page. Under Alternate Resources, reply Y for yes. N for no, beside all resources you have received or applied for in relation to the medical procedure. If Y then in the box to the right of that Resource, enter the amount you have received or will receive.

On Page 2, enter all Assets, real and personal property and funds in cash, checking or savings accounts in the columns on the left of the page. In the columns on the right list all Liabilities, or expenses and outstanding loans that you owe. Sign and date the form.

All forms, Referral and Application, must be returned to; Medical Contingency Fund Selection Committee, Eastern Idaho Community Action Partnership, 357 Constitution Way, PO Box 51098, Idaho Falls, ID 83405, by 4:30 p.m. the 2nd Monday of the month in which you wish your application to be considered for funding. You will be notified before the end of that month by EICAP whether your application has been accepted for funding and the amount of funds to be paid to your provider(s) in your name.

**Eastern Idaho Community Action Partnership
Medical Contingency Fund
Application Form**

Date: _____

Phone Number: _____

Applicant Name: _____
Last First MI

Address: _____
Street City State Zip

Family Members	Relationship to Applicant	Age

Alternate resources applied for:

Resource	Applied For (y or n)	Not Applicable	\$ Amt. received
Private Insurance coverage			
Public Assistance			
Crime victim's Compensation			
Worker's Compensation			
Veteran's Benefits			
County and/or State Medical Indigence Funds			
Catastrophic Funds			
Medicaid			
Medicare			
Social Security Retirement/Disability/Survivor's Benefits (circle one or more)			
Claims in Litigation			
Other: specify			

Please complete and sign page 3 of this application

Household Financial Statement

ASSETS (List of what you own)			LIABILITIES (List of what you owe)		
Cash on Hand			Average monthly costs for:		
			• Food		
			• Clothing		
Balance in Checking (list all accts)			• Rent		
			• Mortgage		
			• Loan Payments		
			• Utilities		
			• Transportation (gas)		
Balance in Savings (list all accts)			• Medical and Dental Care		
			• Education		
			• Insurance (home and/or auto)		
			• Other - describe		
Monthly Net (after taxes) Income					
			Other Current Liabilities – describe		
TOTAL CURRENT ASSETS			TOTAL CURRENT LIABILITIES		
Real Estate			Other Liabilities - describe		
Investments – describe					
Personal Property – describe					
Other Assets – describe					
TOTAL ASSETS			TOTAL LIABILITIES		
			<i>Total Assets minus Total Liabilities</i>		

<i>For office use only</i>	Yes	No
1. Does the procedure qualify for this grant under Section C of the Program Guidelines?		
2. The patient has no source of payment for any part of the service.		
3. The patient has a source of payment for a portion of the cost of the service.		
4. Has the patient exhausted all applicable alternate resources under Section A?		

Everything I have stated in this application is correct to the best of my knowledge. I give my permission to the agent of E.I.C.A.P. to verify and/or release this information to any appropriate organization necessary to provide my household with assistance.

Signature of applicant

Date of Signature