Financial Application for Assistance:

Personal Information:

Applicant Name: _____

Mailing Address: _____

Telephone Number(s): Home: _____ Work: _____

List below the people in your household:

Full Name	Date of Birth	Relationship

1.)_____

2.)_____

3.)_____

4.)_____

5.)_____

6.)_____

7.)_____

Health Insurance Information:

Medical Insurance? Yes _____ No _____
If "yes" print name of insurance
company:_____
Policy Number: _____
Other Coverage? Yes _____ No _____
Please identify other coverage: _____
Medicare _____ Medicaid _____
Have you recently suffered severe financial hardship or personal loss (for example, medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property?
Yes _____ No _____ If yes, please explain:
_____
_____
_____

Do the documents that you are including with this application show your current financial situation correctly?
Yes _____ No _____ If no, why not?

_____

_____

If you are asking for financial assistance or charity care for services already provided by Magic Valley Cares, please list dates of services and what services you received:

_____

_____

Client Worksheet:
Net Monthly Income: Please indicate all sources of income.
Applicant/Guarantor: $_____
Spouse: $_____
Other Income: $_____
Total Net Monthly Income $_____

Monthly Expenses: Please indicate your average monthly expenses for the following items.
Food: $_____
Utilities: $_____
Auto/Gas: $_____
Telephone: $_____
Childcare: $_____
Other: $_____ $_____
Other: $_____ $_____

Total: $_____

Creditors: Please indicate the amount of all monthly payments and to whom the payment is made.
Rent/Mortgage:_____ $_____

Insurance (Auto):_____$_____

Other Payment:_____ $_____

Other Payment:_____ $_____

Total: $_____

Please select the area for which this application pertains to:

For financial help with medical, check this box. ☐

For financial help with clothing, check this box. ☐

For financial help with food, check this box. ☐

For financial help with housing, check this box. ☐

If requesting financial help with utilities, prescriptions or medical services, provide the account information.

I understand that submission of this application does not guarantee approval and any information provided will be verified by Magic Valley Cares.
I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature _____ Date _____

Mail this application with all documentation to:

Magic Valley Cares
P.O. Box 5738
Twin Falls, ID. 83303

or

Submit Online

Be sure to include with your application documents that support the income amounts you list. For example:

- ☐ Pay stubs from all employment or
- ☐ A W-2 withholding statement or
- ☐ Last year's income tax return or
- ☐ Letters approving or denying Medicaid, medical assistance, other benefits or
- ☐ Letters approving or denying unemployment compensation or
- ☐ Written statements from employers or welfare agents.