



## Medically Related Expenses & Emergency Grants

**The following list are reasonable medically related expenses that the organization will fund:**

- Prescription drugs necessitated by the treatment for the patient.
- Medical bills and/or co-pays related to the treatment

**These items are not considered treatment expenses and will not be reimbursed:**

- Entertainment items
- Clothing
- Personal Products
- Rehab therapy not administered by a licensed therapist
- Postage
- Auto repairs
- Computers
- Loss of income
- Expenses unrelated to treatment

*Please note this is not a completed list of expenses.*

### **Guidelines for funding:**

In order for your application to be considered, the following items need to be provided accompanying your application:

Proof of Michigan residency during the last twelve months prior to this application date. Proof of residency can be a utility bill, bank, statement or a driver's license with the expiration date.

Proof of Income— You may either enclose a copy of the most recent State Income Tax or a most recent check stub or social security income statement.

Proof of Health Insurance if applicable—A copy of your Medicare, Medicaid or private insurance card. If you don't have health insurance, please note that you have no insurance.

Receipts for all medically related expenses that you are seeking reimbursement for including documentation: Examples: Copy of medication prescribed and costs and copy of medical bills and



costs.

**Date of Application:** \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_

**Please Print Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Client Information Section:**

\_\_\_\_\_  
First Name Middle Last Name

\_\_\_\_\_  
Street Address Apt./Suite Number

\_\_\_\_\_  
City State Zip Code County

\_\_\_\_\_  
Home Phone Cell Phone E-mail

Male  Female  Married\*  
 Single

\*If married, please provide your spouse's name \_\_\_\_\_

\_\_\_\_\_  
Date of Birth Age

\_\_\_\_\_  
Number in Household Number of Children (living in household)

**Demographical Information:**

\_\_\_\_\_  
Treatment Center Date of Treatment

**Current Sources of Income (Please check all that apply)**

Full-Time employment  with benefits  Social Security Disability (SSDI)  
 Part-Time employment  with benefits  Supplemental Security Income  
 Other \_\_\_\_\_

**Current Healthcare Coverage-Please list what type of insurance you have, if none, state none.**

\_\_\_\_\_ **hn**

**Check all that apply:**

Recipient

Candidate

## **Financial Assistance Application**

**Assets** Do not leave any field's blank in this section

Checking Account \$ \_\_\_\_\_

Savings Account \$ \_\_\_\_\_

Retirement \$ \_\_\_\_\_

Other \$ \_\_\_\_\_

### **Monthly Household Income**

### **Monthly Household Expenses**

**Wages (net)** \_\_\_\_\_ **Rent/Mortgage** \_\_\_\_\_

**Social Security** \_\_\_\_\_ **Food** \_\_\_\_\_

**Pension** \_\_\_\_\_ **Utilities Total** \_\_\_\_\_

**Spouse's Income** \_\_\_\_\_ **Auto Payment/Gas** \_\_\_\_\_

**Retirement Income** \_\_\_\_\_ **Insurance-Medical** \_\_\_\_\_

**Dividends if applicable** \_\_\_\_\_ **Insurance-Life** \_\_\_\_\_

**Other (specify)** \_\_\_\_\_ **Insurance-Auto** \_\_\_\_\_

**Charge Accounts** \_\_\_\_\_

**Other** \_\_\_\_\_

**Total Monthly Income:** \_\_\_\_\_ **Total Monthly Expenses** \_\_\_\_\_

I authorize information released between The Really Living Corporation and my treatment center or other related parties to verify information related to this request. I agree to be added to The Really Living Corporation's mailing list for future mailings.

\_\_\_\_\_  
Applicants Signature

\_\_\_\_\_  
Date



**Contact Information:** \_\_\_\_\_

*All checks will be paid directly to the companies listed above and mailed to the applicant, unless stated otherwise.*

**WE WILL MAKE A DETERMINATION ABOUT YOUR REQUEST WITHIN 30 DAYS.**