**Hamilton Fish Webster Medical Fund**
278 Broadway
Newport, Rhode Island 02840

**The Hamilton Fish Webster Medical Fund Board of Directors has received your request for assistance with the payment of your medical expense(s). To enable the Board of Directors to consider your request, please read and complete *all* sections of this application form, sign, and return to the above address. You must also provide a copy of your most recently filed federal income tax return with your completed application.**

## APPLICANT INFORMATION

Full Name: _____ Social Security Number: _____
Home Address: _____ Date of Birth: _____
City/State/Zip: _____ Home Phone Number: _____
_____ Number of Dependents: _____
Mailing Address: _____ Home: Own ____ Rent: ____ Live with Parents ____
City/State/Zip: _____ How Long: _____

Former Address (if less than 2 years at present)
Address: _____ Monthly Payments for
City/State/Zip: _____ Mortgage or Rent: $ _____
How Long Have you lived
on Aquidneck Island: _____

## EMPLOYMENT & INCOME INFORMATION

**Present Employer:** _____ Employer's Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Current Salary: _____

**Previous Employer:** _____ Employer's Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Previous Salary: _____ Reason for Leaving: _____

**Self Employed**
Name of Business: _____ Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Current Salary: _____

**Other Income**
Source: _____
( ___ Gross ___ Net) $ _____ per _____

## SPOUSE INFORMATION (If Applicable)

Full Name: _____ Social Security Number: _____
Date of Birth: _____
Present Employer: _____ Employer's Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Current Salary (___ Gross ___ Net) $ _____ per _____
Other Income: Source _____
(___ Gross ___ Net) $ _____ per _____

## DEPENDENT CHILDREN INFORMATION (If Applicable)

Full Name(s)/Ages: _____
_____

Please list all outstanding creditors: mortgages, lines of credit, automobile loans, installment loans, credit cards and charge accounts. (Attach additional page if necessary)

| Creditor (to whom owed) | Purpose | Original Amount | Monthly Payment | Balance |
|---|---|---|---|---|
| | | $ | $ | $ |
| | | | | |
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Please list all medical expenses you are submitting to the Hamilton Fish Webster Medical Fund for payment and attach the original itemized statement(s)/invoice(s) for each.

| Medical Expense (to whom owed) | Purpose | Balance |
|---|---|---|
| | | $ |
| | | |
| | | |
| | | |
| | | |
| | | |

Please indicate the nature of your illness or the diagnosis by your attending physician.

Please indicate the name of your current medical or health care insurance provider.

Please indicate the name of your previous medical or health care insurance provider and the dates of coverage.

**Please indicate the name of any federal, state, or local social service agency or program from which you have received benefits within the last twelve (12) months (i.e., Medicare, Medicaid, TRICARE, RIte Care, Social Security, Unemployment, Food Stamps, Welfare, etc.)**

| Agency/Program | Total Benefits/Payment Received |
|---|---|
| | |
| | |

Please indicate any additional information you believe may be helpful in assisting the Board of Directors to consider your request for assistance. (Attach separate page if necessary.)

**All information provided on this application is true and correct to the best of my knowledge. I understand that the Hamilton Fish Webster Medical Fund will retain this form and all supporting documentation substantiating my request for assistance whether or not assistance is approved.**

Signature: _____ Date _____

**CASE #** **FOR HFW MEDICAL FUND USE**