Medical Needs Assistance Program application

FMF & AID
Global Association

Applicant's name: _____

Date of birth: ____ /___/_____ (month/day/year)

Address: _____

City: _____ Postal code: _____ Country: _____

E-mail: _____

Diagnosis: _____

Household size: Number of family members (including you) who live in your home.
Total number: _____

Household income (monthly): Total gross income (before any deductions or taxes) for all family members in the household. Check ALL income types that apply:

☐ Employment income/wages
☐ Unemployment benefits
☐ Disability income
☐ Alimony/child support
☐ Pension or retirement
☐ Social help

Amount: _____ Currency: _____

Household total expenses (monthly average): Please give a rough estimate of all your monthy basic living expenses (i.e. home rent, health insurance, heating/water).

Amount: _____ Currency: _____

Medical financial request for:
☐ Specialist consultation fee
☐ Genetic test (Invitae PID panel – 407 genes)
☐ Prescription medication
☐ Travel costs to specialist
☐ Out-of-pocket medical costs
☐ Other, please specify

_____
_____

Amount requested: _____ Currency: _____

I hereby declare that all information set forth above in this application is true and accurate in all respects. I also agree to provide whatever documents the FMF & AID deems necessary to prove that the information given above is correct. The information in this form will NOT be shared with anyone. If at any point in time you would like us to destroy this form with your information, please let us know and it will be done immediately.

By completing this form, I hereby accept that the FMF & AID Global Association is the sole arbitor in the decision to provide funding or not.

Signature: _____ Date: _____

Note: In the event of a successful application, you will be informed by e-mail. The amount donated by FMF & AID is solely at their discretion.