Cole Foundation

Bringing Hope; Transforming Lives

PATIENT ASSISTANCE APPLICATION

(TO BE USED FOR INITIAL REFERRAL/APPLICATION)

DATE: ______________________________

NAME: ____

ADDRESS: ____

DATE OF BIRTH: ___________ AGE: ____ MARITAL STATUS: ____FAMILY MAKE-UP: _____________

IN HOUSEHOLD: ____ # OF CHILDREN IN HOUSEHOLD: _____HOUSEHOLD INCOME: $_____________

WHAT SERVICES ARE NEEDED: ____

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ANTICIPATED LENGTH OF CARE NEEDED: _______________________

HAVE YOU SOUGHT ASSISTANCE WITH OTHER AGENCIES? IF SO, PLEASE TELL US WHO, WHEN AND HOW MUCH THEY WERE ABLE TO ASSIST YOU?

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All information that you provide us with be kept in the strictest of confidence. We will evaluate your situation and offer resources that might be available to you. We will attempt to help you if we are able. Each request is taken under careful, prayerful consideration. Please know that the availability of funds to assist you depend on the donation from others and may or may not be available at this time. The Cole Foundation also reserves the right to utilize your basic information, excluding all identifying information, to help promote the Foundation and to attempt to secure funding for future requests. You are only able to request assistance from the Cole Foundation on an annual basis.