1425 Grand Rd., Winter Park, FL 32792 321-236-0520

Wingmen Foundation
Request for Financial Services
PHYSICAL THERAPY FINANCIAL ASSISTANCE

Application Requirements:

- Must be a United States resident
- Medical Verification Form
- Signed Certification and Release

Please type or print in ink all information requested. Signed applications and supporting materials must be received by **25th of each month**. The Wingmen Foundation Financial Services Department will review applications at the end of each month, and funds, if any, will be dispersed the beginning of the following month.

Funds will be dispersed directly to the organization and not to the applicant.

Financial Assistance Requests Include:

- Physical Therapy Sessions
- Physical Therapy Co-Pays

Please email your complete financial services application documents to:

FS@wingmenfoundation.org

For questions, please email FS@wingmenfoundation.org.

Application Checklist

- [ ] Completed, signed and dated **Application**
- [ ] Letter of **Verification** from physician or treatment center. Treatment center or physician-signed "travel" letter is acceptable
- [ ] Letter or proof from the insurance company showing patient has maxed out on physical therapy sessions covered by insurance for the physical year
- [ ] Copy of the Co-pay invoice from the physical therapy office or Explanation of Benefits (EOB) from the insurance company
- [ ] Signed and dated **Release**

Application Form - page 1

Personal Information:

Last Name __________________________ First Name ______________________ Middle Initial______

Address _______________________________________ Home Phone ____________________________

_______________________________________ Cell Phone ____________________________

Email Address ____

Date of Birth __________________________ ☐ Male ☐ Female

Medical Condition

____

Severity (if applicable) ☐ Mild ☐ Moderate ☐ Severe ☐ Inhibitor

Physician Name and Phone Number ____

Hemophilia Treatment Center (if applicable)____

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Services:

How did you hear of the Financial Services Program offered by Wingmen Foundation?

☐ Facebook

☐ Direct mailing

☐ Online Listing (please name) ____

☐ Wingmen Foundation personnel (please name) ____

☐ Chapter or Foundation (please specify) ____

☐ HTC Personnel (please name) ____

☐ Other (please specify) ____

Application Form - page 2

Physical Therapy Office Information:

Please list the physical therapy office, contact & phone number, & mailing address for funds to be dispersed:

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Explanation of Request:

Reason for Physical Rehabilitation:

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Application Form - page 3

Gross Annual Income & Expenses:			
Household Income:		**Household Expenses:**	
Employment	$	Mortgage/Rent	$
Government Assistance	$	Electric/Gas/Water	$
Child Support	$	Insurance	$
Food Stamps	$	Phone	$
Student Loans	$	Medical Expenses	$
Other	$	Credit Cards	$
-	-	Auto Loans	$
TOTAL	$	**TOTAL**	$

Reason for Request:

Please describe your circumstances/reason for applying for financial assistance, including any unusual expenses you must meet (attach additional pages if necessary):

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Certification and Release

Applications received by the Wingmen Foundation Financial Services Program will be reviewed and approval for request of financial assistance will be reviewed by the Financial Services Department at the end of each month, and funds, if any, will be dispersed at the beginning of the following month. All decisions made are final. It may be necessary for someone from the Financial Services Department to contact you directly for a personal interview or to qualify any information contained in this application.

Funds will be dispersed directly to the organization and not to the applicant. Applicant must show accountability by participating in a continuous manner if funds dispersed are for ongoing sessions. Wingmen Foundation will continue to follow up to ensure applicant is compliant with the financial request accountability. If applicant is not compliant in continuing the rehabilitation sessions, assistance will be extinguished. Please notify Wingmen Foundation if individual is having medical issues and/or is having gaps of attendance due to medical reasons and not able to continue the rehabilitation sessions or is in need of a leave of absence. Wingmen Foundation will not pay for any missed sessions unless reason was for a medical emergency of individual or family member.

I have personally signed this Wingmen Foundation Financial Services application. I certify that all statements contained in the foregoing application are true and correct.

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Printed Name

____ ___________________________

Signed Name Date

If applicant is under age 18, please include a parent or guardian's signature

____ ___________________________

Parent or Guardian Printed Name Phone Number

____ ___________________________

Parent or Guardian Signed Name Date

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Basis of Authorization

MEDICAL VERIFICATION FORM
Physician or Treatment Center

Dear Applicant: Please fill out your name and address and give this form to your physician or hemophilia treatment center. A copy of a letter signed by your physician or treatment center (such as a travel letter) verifying your bleeding disorder may be substituted for this form. It is your responsibility to see this form is submitted by the **25th of the month**.

Name of Applicant ____

Address of Applicant ____

To be completed by applicant's Physician or Nurse

What type of bleeding disorder has this scholarship applicant been diagnosed with?

☐ Hemophilia A ☐ Hemophilia B Severity: ☐ Mild ☐ Moderate ☐ Severe

Inhibitor: ☐ Yes ☐ No

☐ von Willebrand ☐ Type 1 ☐ Type 2 ☐ Type 3 Severity______________________________

☐ Other (please specify)____

____ ________________________

Physician/Nurse Signed Name Date

____ ________________________

Physician/Nurse Printed Name Phone number

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Treatment Center or Medical Facility

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Treatment Center or Medical Facility Address

Please return this form to the patient by the **25th of the month**.