

# **Easter Seals Birmingham Area Medical Assistance Grant Program**

200 Beacon Parkway West, Birmingham, AL, 35209  
(205) 942-6277, fax (205)945-4906



*Creating solutions, changing lives.*

*The purpose of this program is to assist in paying for medical requirements of children and adults who have disabilities and who are unable to provide for their own needs and for whom no other resources are available.*

*Easter Seals Birmingham Area serves residents of Jefferson, Shelby, Walker, Blount, and St. Clair Counties.*

*To be considered for assistance with medical needs, **the two page application that follows must be filled out completely. Requests for assistance will be reviewed on the last working day of each month.***

*The following information must be presented with the application:*

- ∞ Referral source – Qualified agency, professional or physician to verify disability and medical necessity of item(s) requested – information must be current (within one year)*  
∞
- ∞ Financial need – Application must include all financial information, along with any other pertinent information to verify circumstances, and confirmation that there are no other resources available. Please include **ALL** household income on application.*  
∞
- ∞ Request – Detailed information regarding item(s) requested, including vendor and prices. Requests exceeding \$500.00 cannot be considered. We will not purchase or participate in the purchase of any item or service over \$500.00*  
∞

*The following items are not ordinarily covered by the  
Easter Seals Medical Assistance Program:*

- ∞ Bills of any kind, including equipment already purchased; respite care; hearing aids; prescription and non-prescription medication; ongoing treatment/therapy; surgical procedures; diagnostic testing; eyeglasses; doctor visits; **vans; automobiles***
  - ∞ Other limitations may apply*
  - ∞ Assistance is limited to availability of funds*



**EASTER SEALS**  
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 (see cover page  
 before submitting  
 application)

**PLEASE PRINT**

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Application Completed By: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Applicant Address: \_\_\_\_\_  
 (street) (city, state, zip)

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Applicant's Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Parent/Guardian/Spouse Name: \_\_\_\_\_

Parent/Guardian/Spouse Address: \_\_\_\_\_  
 (If both parents are employed, (street) (city, state, zip)  
 include additional information on back)

Parent/Guardian/Spouse Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Parent/Guardian/Spouse Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Total Number Household Members: \_\_\_\_\_ Children (under 18) \_\_\_\_\_ Adults: \_\_\_\_\_ Adults Employed FT \_\_\_\_\_ PT \_\_\_\_\_

**ARE YOU RECEIVING BENEFITS FROM ANY OF THE FOLLOWING SOURCES? IF SO, CHECK ALL THAT APPLY**

Medicare \_\_\_\_\_ Private Ins. (Company name) \_\_\_\_\_

Medicaid \_\_\_\_\_ Food Stamps: \_\_\_\_\_ Amount: \_\_\_\_\_

CRS: \_\_\_\_\_ Vocational Rehab: \_\_\_\_\_ Counselor: \_\_\_\_\_

Who referred you to Easter Seals?: \_\_\_\_\_

With what agency / organization is this person affiliated? \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever received services from Easter Seals? Yes No If so, please give date:

(use back if necessary)

Applicant's Disability: \_\_\_\_\_

**Item(s) you are requesting, including cost and vendor:**

\_\_\_\_\_

**FOR CONSIDERATION OF FUNDING YOU MUST SEND (1) Proof of disability (2) Proof of need as related to disability (from Dr. or referral source) (3) Written estimate from the supplier and/or prescription and written estimate from vendor. ATTACH ALL DOCUMENTATION THAT IS RELEVANT TO THIS REQUEST. Please note - payment will only be made to a licensed business, agency, etc. THIS FORM MUST BE FILLED OUT COMPLETELY, AND INCLUDE ABOVE ITEMS FOR CONSIDERATION.**

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(Name:) ☺ \_\_\_\_\_

**HOUSEHOLD INCOME**

**From Employment:** Parent/Guardian/Spouse (**Total household**)  
 Applicant's Annual Gross Income: (amount) \_\_\_\_\_ Annual Gross Income: (amount) \_\_\_\_\_

**From Other Sources:**

SSI Benefits \$ _____	Private Retirement \$ _____
Soc. Sec. Disability \$ _____	AFDC \$ _____
Soc. Sec. Retirement \$ _____	Child Support \$ _____
Soc. Security Survivors: \$ _____	Unemployment \$ _____
Other \$ _____	_____

**MONTHLY EXPENSES WORKSHEET**

**Household Expenses:**

House note/rent\$ \_\_\_\_\_ Electricity\$ \_\_\_\_\_ Gas\$ \_\_\_\_\_ Water\$ \_\_\_\_\_ Phone \$ \_\_\_\_\_

Groceries(per month) \_\_\_\_\_ Cable TV \_\_\_\_\_ Gasoline \_\_\_\_\_ Day Care/Tuition \_\_\_\_\_

Car Note #1 \_\_\_\_\_ (year/make/model \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_)

Car Note #2 \_\_\_\_\_ (year/make/model \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_)

**Insurance Premiums:** (please indicate payment amount)

Medical \_\_\_\_\_ Life/Burial \_\_\_\_\_ Automobile \_\_\_\_\_  
 Home/Renters \_\_\_\_\_

**Personal Loans** (please indicate amount)

Bank \_\_\_\_\_ Credit Union \_\_\_\_\_ Finance Company \_\_\_\_\_ (name of company) \_\_\_\_\_

Finance Company \_\_\_\_\_ (name of company) \_\_\_\_\_

Furniture/Appliance \_\_\_\_\_

**Credit Cards:** (please indicate payment amount)

Mastercard \_\_\_\_\_ VISA \_\_\_\_\_ Discover \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

**Medical Costs:** (not covered by insurance) (please indicate amount due / payment amount)

Doctors \_\_\_\_\_ / \_\_\_\_\_ Hospitals \_\_\_\_\_ / \_\_\_\_\_ Dentists \_\_\_\_\_ / \_\_\_\_\_

Other Professionals (physical therapists, anesthesiologists, \_\_\_\_\_)

**The above information is true to the best of my knowledge. I agree to make available proof of the above information upon request. I give Easter Seals permission to discuss information regarding this request with referral sources and/or vendors as necessary.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

FOR OFFICE USE ONLY

Total Household Expenses _____	Total Credit Cards _____	Total Monthly Expenses _____
Total Insurance Premiums _____	Total Medical Costs _____	Total Income _____
Total Personal Loans _____	Total Miscellaneous _____	
Date Application Received: _____	Complete? _____	Date Approved: _____

Amount: \_\_\_\_\_ Check # \_\_\_\_\_ Date Paid: \_\_\_\_\_ Paid to: \_\_\_\_\_

Date Application Disapproved: \_\_\_\_\_

Reason: \_\_\_\_\_

Additional Information: \_\_\_\_\_