

HABER DIABETIC FOUNDATION

APPLICATION FOR FINANCIAL AID



This form must be completed and signed in order to receive financial assistance for diabetes related expenses offered by the Haber Diabetic Foundation. Financial Aid applicants are notified of award in advance of the program by phone or regular mail.

Date submitted _____

DIABETIC CHILD'S NAME _____ Date of Birth _____

Address _____

Name of Parent or Guardian _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name & relationship of person completing this form _____

Total monthly amount of assistance to which you are applying _____

THE FOLLOWING INFORMATION MUST BE COMPLETED IN FULL

The Haber Diabetic Foundation is not associated with any national diabetes organization and has limited financial aid resources. Therefore to ensure coverage for all in need, we must take into account the income of all individuals living in the household including step-parents.

	Name	Place of Employment	Position
Mother	_____	_____	_____
Father	_____	_____	_____
Step-parent	_____	_____	_____
Step-parent	_____	_____	_____
Foster parent	_____	_____	_____
Custodial Grandparent	_____	_____	_____

Number of people living in household in which DIABETIC CHILD resides _____

NAME	RELATIONSHIP	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Monthly Family Income – TOTAL for ALL living in the household

Salaries and Wages \$ _____

Other sources of income
(Disability, social security, retirement, unemployment) \$ _____

Child Support \$ _____

TOTAL GROSS MONTHLY FAMILY INCOME \$ _____

Please note any unusual or special financial circumstances that may require consideration

Please answer the following questions:

Is DIABETIC CHILD in foster care? __YES __NO

Is household eligible for food stamps? __YES __NO If yes, number _____

Is DIABETIC CHILD eligible for reduced school lunch? __YES __NO

Is DIABETIC CHILD eligible for free school lunch? __YES __NO

Is DIABETIC CHILD eligible for Medicaid? __YES __NO Medicaid number (required) _____

Is DIABETIC CHILD seen by Children's Medical Services for health/medical care? __YES __NO

REQUIRED: CMS Network Number _____ CMS Care Coordinator Name _____

Care Coordinator Phone number with area code & extension _____

Please submit a copy of your Medicaid and/or CMS Network card with this application

We encourage families to seek their own sponsorships through local service organizations such as Kiwanis, Rotary, Lions, Eagles, Veterans or other clubs. Grants are also often available through employers and churches. Any amount raised by the family in this way, may be matched by our scholarship fund. If you have secured a sponsorship from another source already please indicate:

SPONSOR NAME (Club, Individual, Business etc.) _____

Contact Person _____

They have pledged \$ _____

Sponsor Address _____

City _____ State _____ Zip _____

Sponsor check should be made out to Haber Diabetic Foundation and indicate the DIABETIC CHILD'S name in bottom left corner and mailed to address below.

By applying for financial assistance I give permission for Haber Diabetic Foundation, Inc. to use our name and our child's name when seeking scholarship assistance specifically for our family. Further I certify that the statements and information made in this application are true and correct.

Legal Guardian/Parent must sign

Date

MAIL OR FAX THIS FINANCIAL AID APPLICATION:

ADDRESS: HABER DIABETIC FOUNDATION, 14352 BISCAYNE BLVD, NORTH MIAMI BEACH, FL 33181

FAX: 305-716-9116