PMR CHARITY REQUEST FORM

- **Fill out** *Application for Charitable Funds* (FORM A)
- **Fill out** *PMR Charity Cost Report* (FORM B)
- **Provide Copies** of Invoices (e.g bills)
- **Fax A, B, and C** to **817-887-4242** and write "ATTENTION PMR CHARITY" on your Fax Cover Sheet
- DO NOT MAIL APPLICATION TO P.O. BOX!
- If you do not hear back within 5-7 business days, email us at pmrcharity@yahoo.com If you do not have email access, you may call 817-336-7188 and ask to leave a message for the "PMR CHARITY ON CALL PERSON".

This is a charitable organization not subject to rigors of HIPAA Compliance or Enforcement. However, PMR Charity takes every precaution to maintain the confidentiality of your records. Email is the most efficient way for us to gather information and access your situation as a team. This is a disclosure and your consent to allow email communication with PHI (protected health information) and PPI (protected personal information) which includes medical, personal and financial information.

IN ORDER FOR YOUR APPLICATION TO BE PROCESSED, YOU MUST COMPLETE ALL THE STEPS LISTED ABOVE.

Please use this updated application, current as of November 1, 2016. Previous forms of the application will no longer be accepted.

Application for Charitable Funds (FORM A)

Name: _____ Date: _____
Date of Birth: _____

Please describe items/ services needed (Ex: medications, brace, home modifications, etc.)

_____
_____

Which avenues have you pursued, prior to submitting this application, in order to fund the items/ services listed above? (Insurance, government assistance, charity)

_____
_____
_____

Please provide a detailed history of the medical condition/injury that has resulted in your need for the items/ services listed above.

_____
_____
_____
_____
_____
_____
_____

Please describe the financial hardship which has resulted in your inability to pay for the items/ services listed above. (Ex: out of work due to recent illness)

_____
_____
_____

(If more room is needed to answer any of these questions, please attach additional papers)

Name of Physician involved in your care:

_____

Physician's Address:
_____
_____
_____

Physician's Phone Number:_____

Name of Case Manager (if applicable):
_____

Case Manager's Phone Number:_____

May we contact your Physician/Case Manager with questions regarding your medical history: YES / NO (please circle)

Applicant Contact Information

Applicant's Address:
_____
_____
_____

Applicant's Phone Numbers:
(H)_____
(C)_____
(W)_____

Applicant's Email:_____

Rules of the PMR Charity Application:

- All applications received will go to a voting board. The board members are determined by the Chairman of PMR Charity Golf.
- Once an application is received, the applicant's request including medical information will be discussed within the board. Discussion with attending physician/ case managers may be warranted for clarification.
- Applicants will be notified once a decision is made.
- Money will not be given to the applicant, but will be paid directly to the vendor. For example, if a leg brace is needed, PMR Charity will pay the orthotics company directly.
- Anonymous summaries of approved applications are posted to social media sites such as Facebook and Twitter. No names will be used. This informs our donors about the allocation of their funds.

By signing below, the applicant acknowledges all rules of the PMR Charity Application as delineated above.

Applicant's Signature:_____

Printed name:_____

Date:_____

Cost Report (FORM B)

Name:_____

ITEM	COST
Total=	$_____

****YOU MUST ATTACH INVOICES/BILLS****