Options For Life Foundation

P.O. Box 8476
Calabasas, California 91372-8476
(818) 222-7738
assistance@oflf.org

CONFIDENTIAL APPLICATION

General Information: *Please answer all questions*		
Applicant's Name:	Social Security No.:	Birthdate:
Address:	Home Phone No.:	Work Phone No.:
	Cell Phone No.:	Fax No.:
Employment Status: ☐ Retired ☐ Disabled ☐ Employed ☐ Unemployed		
Spouse's/Partner's Name:	Social Security No.:	Birthdate:
Spouse's/Partner's Address (if different):	Spouse's/Partner's Telephone No's (if different) Home Phone No.:	Work Phone No.:
	Cell Phone No.:	Fax No.:
Employment Status: ☐ Retired ☐ Disabled ☐ Employed ☐ Unemployed		

Name two individuals who can be contacted if you cannot be reached: (Such as adult children, friends, etc.)

Name:_____ Relationship:_____

Address/Phone No.:_____

Name:_____ Relationship:_____

Address/Phone No.:_____

List current/former employer(s), position(s) held, and year(s) employed.

Employer Name	Position(s) Held	Year(s) employed

Health Information:

Applicant's Doctor:_____ Phone No.:_____

Spouse's Doctor:_____ Phone No.:_____

Name of Applicant's Primary Health Insurance:_____ Policy Number:_____

Name of Applicant's Secondary Health Insurance: _____ Policy Number:_____

Name of Spouse's Primary Health Insurance:_____ Policy Number:_____

Name of Spouse's Secondary Health Insurance: _____ Policy Number:_____

Please indicate any health conditions, or illnesses:_____

_____

_____

_____

If you do not have income or expenses, please check this box ☐, sign below and return with application

Income (from employment, unemployment, disability, charity grants, pension, social security, rental income, dividends, interest income, alimony, etc.)

Applicant:	Spouse:
1. Issued by: _____	Issued by: _____
Amount: _____	Amount: _____
2. Issued by: _____	Issued by: _____
Amount: _____	Amount: _____
3. Issued by: _____	Issued by: _____
Amount: _____	Amount: _____

Expenses: (Estimate basic monthly costs)

Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
Rent:		Car Loan:	
Renter's Insurance:		Car Lease Payment:	
Mortgage:		Car Insurance:	
Home Owner's Insurance:		Gasoline Costs:	
Property Taxes:		Other transportation costs:	
Food/Household supplies:		Installment debts:	
Electric/Gas/Water/Garbage:		Installment debts:	
Telephone:		Installment debts:	
Life Insurance:		Other expenses:	
Medical Insurance:		Other expenses:	
Medications not covered by insurance:			
Medical co-pays or deductibles:			

List the names and ages of those who live in the home:

_____

Real Estate (Primary Residence, Vacation Home, Rental Property, Vacant Land, Etc.)

Address: _____ City: _____ State: _____ Zip _____

Monthly Mortgage: _____ Balance Owed: _____ Current Value: _____

Bank Accounts, Credit Union Accounts, Retirement Accounts:

Institution: _____	Institution: _____
Current Balance: _____	Type of Account: _____
Institution: _____	Institution: _____
Current Balance: _____	Type of Account: _____

Additional assets, list here:

Other Personal Property (Automobiles, Recreational Vehicles, Boats, Motorcycles, Etc.)	
Description:_____	Value:_____
Registered Owner:_____	Legal Owner:_____
Balance Owing:_____	Market Value:_____
Are Payments Delinquent?: □ Yes □ No	If so, Amount:_____
Description:_____	Value:_____
Registered Owner:_____	Legal Owner:_____
Balance Owing:_____	Market Value:_____
Are Payments Delinquent?: □ Yes □ No	If so, Amount:_____

RELEASE OF INFORMATION, FINANCIAL DISCLOSURE AND UNDERSTANDING:

Please initial after each statement and sign at the bottom of the application:

1. I hereby certify that I have answered the foregoing questions to the best of my ability, the facts therein stated are true and I understand that any misrepresentation of this information may disqualify me for any assistance from the Options For Life Foundation. I further agree to notify the Options For Life Foundation of any changes in my financial situation if such occurs during the time I am receiving assistance. **(Applicant's initials)_____(Spouse's/Partner's initials)**_____

2. I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested with regard to medical treatment, dates of medical service, health condition, and medical expenses to the Options For Life Foundation and its representatives.
(Applicant's initials)_____(Spouse's/Partner's initials)_____

3. I hereby authorize the Options For Life Foundation and its representatives to communicate with responsible relatives to secure information regarding earnings from employers, to contact financial institutions for financial data and to contact any other agency or persons regarding my financial status. **(Applicant's initials)_____(Spouse's/Partner's initials)_____**

4. The undersigned, recognizing that his or her individual credit history may be a necessary factor in the evaluation of this application, hereby consents to and authorizes the use of a consumer credit report on the undersigned, by Options For Life Foundation .
(Applicant's initials)_____(Spouse's/Partner's initials)_____

5. I agree to provide all disclosures of my financial assets. I agree that by submitting this application I have not given away or transferred any assets within the last 12 months in order to qualify for assistance. I understand that if the Options For Life Foundation discovers such a give-away or transfer, my assistance will be terminated immediately.
(Applicant's initials)_____(Spouse's/Partner's initials)_____

6. I understand that the assistance I may receive is charitable in nature and intended to provide support during a short recovery or adjustment period. I understand that if I am granted assistance while owning liquid assets worth up to three (3) times my usual monthly income, I will use these assets wisely to meet necessary monthly obligations. The Options For Life Foundation views liquid assets as those assets which can be quickly and cheaply converted into cash such as bank deposits, money market fund shares, U.S. treasury bills, and recreational vehicles, etc. Other assets such as one's primary home is viewed as an illiquid asset, which generally can only be sold after a long search for a buyer.
(Applicant's initials)_____(Spouse's/Partner's initials)_____

*Please enclose your most recent tax return in addition to submitting this completed application.

The items initialed above indicate that I have read them and am in full agreement.

_____
Date Applicant's Signature

_____
Date Spouse's Signature

Release to Obtain and Disclose Information

I/We, _____, authorize the Options For Life Foundation™ Social Services staff to obtain and disclose pertinent information from my/our records to/from the indicated entities:

- ☐ Insurance company
- ☐ Organizations
- ☐ Employer
- ☐ Hospital/Doctor's Office
- ☐ Local/Union
- ☐ Physician
- ☐ Pharmacist
- ☐ Utility companies
- ☐ Other:

This authorization is valid only for the period of one year from the date listed below at signature.

I/We understand that my/our records are protected under the Federal Confidentiality Regulations as well as the provisions of HIPPA of 1996 and cannot be disclosed without my/our written consent unless otherwise provided for the regulations. I/We understand that I/we may revoke this consent at any time, provided action has not been taken in reliance upon this authorization. Without written notice to withdraw this consent, it expires at the earlier of the listed expiration date or upon release of the information. The nature of this consent form has been explained to me/us and I/we understand its contents. I/We are aware that when my/our medical records reflect information concerning psychological or psychiatric impairments, drug abuse, and/or alcoholism, and/or information regarding human immunodeficiency virus (HIV) and other infectious diseases, that this information will be released as part of my/our medical records.

_____

(Signature of Applicant) (Date)

_____

(Signature of Applicant's Spouse) (Date)

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