PATIENT NAME:_____ DATE:_____

PE**RSONAL DATA** — TO BE COMPLETED BY APPLICANT (parent, legal guardian, or POA if applicant is under 18)

Answer each question completely. Print clearly and use dark ink.

Applicant Name :			
Parent, Guardian, or POA Name (if under 18) :			
Applicant Date of Birth :		Age:	
Address :		Apt #	
City :	State :	Zip :	County :
Phone	Cell :	Work :	Home :
Email Address :			
Additional contact person with whom we may discuss your application:			
Name / Contact information :			
How and when is the easiest time to reach you?			
Preferred Language?			
Are you currently employed? Yes No		Are you disabled? Yes No	
Please Describe in detail what type of assistance you are seeking from the Fishstrong Foundation:			

****MUST BE SIGNED BY APPLICANT OR REPRESENTATIVE****

I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize The Fishstrong Foundation to obtain from the individuals, businesses, organizations, agencies, or entities listed in this application whatever information is necessary about my case that might be helpful for assessing my application. I release The Fishstrong Foundation of all liabilities or claims arising out of the donation of money or services provided to me or my family.

Signature :	**Date :**

Applicant Name: ____

Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / _____	☐

Applicant Name: _____

Household Monthly Expenses

Name of Expense	***Amount / How Often***
RENT / MORTGAGE PAYMENT	***$***_____***/***_____
HOME OWNERS / RENTERS INSURANCE	$ _____ / _____
POWER	$ _____ / _____
WATER	$ _____ / _____
TRASH	$ _____ / _____
CABLE / INTERNET / HOME PHONE	$ _____ / _____
CAR PAYMENT	$ _____ / _____
CAR INSURANCE	$ _____ / _____
GROCERIES	$ _____ / _____
GAS	$_____/_____
MEDICAL INSURANCE	$_____/_____
CREDIT CARDS	$_____/_____
CELL PHONE	$_____/_____
	$_____/_____
	$_____/_____
	$_____/_____
	$_____/_____
	$_____/_____

Does your family receive food stamps?	YES_____ NO_____
If NO, do you plan to apply?	YES_____ NO_____
Is patient on Medicaid?	YES_____ NO_____
If NO, do you plan to apply?	YES_____ NO_____
Does patient receive SSI or disability?	YES_____ NO_____
If NO, do you plan to apply?	YES_____ NO_____

EMPLOYMENT VERIFICATION LETTER

Employer Name: _____

Address: _____

City: _____ State: _____

Zip: _____

RE: Verification of Employment for _____ [Name of Employee]

To whom it may concern:

Please accept this letter as confirmation that _____ [Name of Employee] has been employed with _____ [Employer Name] since _____ [Employee Start Date]. Currently, _____ [Name of Employee] holds the Title of _____ and works on a ☐ Full-Time ☐ Part-Time basis of ____ hours per week while earning $_____ payable ☐ Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually and ☐ No Bonus ☐ a Bonus of $_____.

If you have any questions or require further information, please don't hesitate to contact me at _____ [Employer Phone Number].

Sincerely yours,

Signature _____ Print Name: _____

Employer Title: _____

PATIENT NAME:_____ DATE:_____

MEDICAL VERIFICATION FORM—TO BE COMPLETED BY MEDICAL PROFESSIONAL

Answer each question completely. Print clearly and use dark ink. Do not use abbreviations or codes for diagnosis and treatment.

Parent/Guardian name (if patient is under 18):	
Medical diagnosis:	Date of diagnosis:
Describe current treatment:	
Physicians Name :	
Is patient currently able to work? Yes No	
If no, what date will patient return to work?	
Is patient disabled? Yes No	Date of disability:
****For the application to be eligible, we must have the following contact information****	
Name of Medical professional (*completing form*):	
Facility Name:	
Address:	
Phone Number: Fax Number:	
Email:	
Referring professional's summary regarding patient :	
****MUST BE SIGNED BY MEDICAL PROFESSIONAL****	
My signature below affirms the diagnosis and treatment information as described on this page.	
Signature :	Date :

HIPAA Privacy Authorization Form **Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

****1. Authorization****

I authorize _____(healthcare provider) to useand disclose the protected health information described below to _____(individual seeking the information).

****2. Effective Period****

This authorization for release of information covers the period of healthcare from: a. □ _____ to _____. **OR**

b. □ all past, present, and future periods.

****3. Extent of Authorization****

a. □ I authorize the release of my complete health record

OR

b. □ I authorize the release of my health record with the exception of □ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing orclaims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time thi s authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. Signature of patient or personal representative Printed name of patient or personal representative and his or her relationship to patient.

_____

Signature of Patient or legal representative

_____

Printed Name of Patient or Legal Representative and Relation to Patient

_____

Date

STANDARD PHOTO RELEASE FORM

Recipient's Name: _____

As the above named recipient or their legal power of attorney I hereby authorize The Fishstrong Foundation to publish the photographs taken of me (the recipient), and my name (the recipient), for use in the Fishstrong Foundations printed publications, Facebook, and website. I acknowledge that since participation in publications, Facebook, and websites produced by Fishstrong Foundation is voluntary, there will be no financial compensation. I further agree that participation in any publication, Facebook post, and website produced by Fishstrong Foundation confers upon me (the recipient) no rights of ownership whatsoever. I release Fishstrong Foundation, its contractors and its employees from liability for any claims by me (the recipient) or any third party in connection with my participation.

Signature:_____ Date:_____

Relationship if not recipient:_____

Street Address:_____

City, State, Zip:_____

STANDARD PHOTO RELEASE FORM FOR MINOR CHILDREN

I hereby authorize Fishstrong Foundation to publish the photographs taken of me and/or the undersigned minor children, and our names, for use in the Fishstrong Foundations printed publications, Facebook, and website. I release the Fishstrong Foundation from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize the Fishstrong Foundation to use their photographs and names. I acknowledge that since participation in publications, Facebook, and websites produced by the Fishstrong Foundation is voluntary, neither the minor children nor I will receive financial compensation. I further agree that participation in any publications, Facebook, and websites produced by the Fishstrong Foundation confers no rights of ownership whatsoever. I release the Fishstrong Foundation, its contractors and its employees from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children.

Signature: _____ Date: _____

Street Address: _____

City, State, Zip: _____

Names and Ages of Minor Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____