VELEY FOUNDATION
EST. 2019
P.O. Box 3434
Allentown, PA 18106
(267) 362-4310

Treatment Grant Application

Veley Foundation offers financial assistance for medically necessary care provided to eligible individuals and families. Your financial need will determine the reduction or elimination of your financial obligation.

The process to apply for a treatment grant is as follows:

- Complete Veley Foundation's Treatment Grant application below
- Include documentation listed on treatment grant checklist
- In order to determine eligibility, Veley Foundation will need proof of your income and household size (we use the Federal Poverty Guidelines to determine financial need)
- Income used to determine eligibility includes, but is not limited to, wages, Social Security, IRA, Worker's Compensation, auto, liability, Medicaid, etc
- If needed, Veley Foundation will assist in setting up a payment plan for any balance for which you are financially responsible
- After you complete the application, Veley foundation will inform you in writing if you qualify for the treatment grant program

If you have any questions regarding this application process please email veleyfoundation@gmail.com

Complete this **treatment grant documents checklist** if you are experiencing a financial hardship and

1. You have income
   - ☐ Attach a copy of your most recent Federal Income Tax Return (1040 Page 1&2, 1040A, 1040EZ, If you filed taxes or are claimed as a dependent, you must supply a copy of the return)
   - ☐ If you cannot locate a copy of your return, you must request a free transcript from the IRS by (www.irs.gov/Individuals/Get-Transcript) or calling 1-800-908-9946 or 1-800-829-1040
   - ☐ We reserve the right to request a free transcript at any time
2. You did not file a federal tax return, you must:
   - ☐ State in writing why you did not file a Federal Income Tax Return on separate piece of paper AND contact the IRS for a free Non-Filing Status Letter at 1-800-908-9946 or 1-800-829-1040
   - ☐ Send us a copy of the most recent federal income tax return of anyone who claimed you as a dependent
3. Attach additional proof of household income if applicable:

"Household income" refers to all individuals who are claimed as dependents on your federal tax return

- ☐ 1099 forms or award letters: Social Security, Pension/Retirement, Disability, etc http://www.ssa.gov/onlineservices/
- ☐ Unemployment Notice of Financial Determination or Workers Compensation

Pay stubs for the last three months or the most current year to date pay stub

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- If you are self-employed, you must include a schedule C and/or statement of income and expenses.

4. You have no income, or no reported income:
   - A notarized letter of no income will be required
5. Proof of identification
   - Current driver's license
   - Valid U.S. Passport

Name of Patient and parent if patient is under 18 years old:	Parent's social security number if patient is under 18 years old:
Patient's date of birth: OR Patient's date of birth: **AND** Parents date of birth if patient is under 18:	Patient's Social Security Number:
Address:	County:
Phone Number:	Alternate phone number:
Employer Name:	Spouse's Name: Spouse's Employer Name: Spouse's Social Security number:

Dependents that are reported on your Federal Tax Return are defined as:

-they live with you for more than half of the year
-do not provide more than half of their own support for the year
-permanently disabled
-are under the age of 19
-are under the age of 24 but are a student

Number of dependents- include yourself if you are the patient

Name	Relation to the patient	Date of Birth	Name	Relation to the patient	Date of Birth

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Medical Resources: Do you have a health savings account (HSA) or a flex spending account (FSA)? If so,

Account Name:	Account Number:

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your Federal Tax return and other proof of income documents (see treatment grant documents checklist).

	Self	Spouse and/or other household members		Self	Spouse and/or other household members
Wages/Self-Employment			Unemployment		
Social Security			Workers Compensation		
Pension or retirement income			Alimony and child support		
Dividends and Interest			Other income:		
Rents and Royalties			Total Monthly Family Income		

I certify that the above information is true and complete to the best of my knowledge. I understand that this application is made so that Veley Foundation can determine my eligibility for financial assistance. If any information I have given is false, I understand that Veley Foundation will re-evaluate my financial status and qualification for a treatment grant or any kind of financial assistance.

I authorize my bank, loan institution, insurance company, employer, or any creditor whatsoever of the undersigned to release any information requested by Veley Foundation pertaining to any and all financial matters involving or relating to the undersigned.

Signature: _____ Date: _____
Relationship to Patient: _____
Approved by: _____ Date: _____

Email completed form and supplemental documentation to **veleyfoundation@gmail.com**