**METROLINA ASSOCIATION FOR THE BLIND HARDSHIP APPLICATION**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NUMBER OF PEOPLE IN HOUSEHOLD \_\_\_\_\_\_\_ AGES OF THOSE UNDER 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIST ALL SOURCES OF HOUSEHOLD INCOME: Source (wages, social security, pension, etc) Monthly Net Income**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU RENT OR OWN YOUR HOME? RENT \_\_\_\_ OWN \_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIST ALL OUTSTANDING DEBTS (auto loans, credit cards, doctor & hospital bills, child support, etc.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_ BAL $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_ BAL $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_ BAL $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_ BAL $\_\_\_\_\_\_\_\_\_\_\_\_\_**

**UTILITIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CABLE TV/INTERNET\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OUT OF POCKET MEDICAL EXPENSES \_\_\_\_\_\_ MONTHLY PAYMENT $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU APPLIED FOR MEDICAID? YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_ IF YES, PLEASE PROVIDE THE STATUS OF YOUR APPLICATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I FURTHER CERTIFY THAT NO OTHER SOURCE IS RESPONSIBLE FOR PAYING THIS BILL.***

***Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\*\*\* TO PROCESS THIS APPLICATION PLEASE INCLUDE THE FOLLOWING: \*\*\* -* Proof of income (paycheck stubs, tax return, Social Security Benefit Verification Letter, etc) - Copy of 2 most recent Checking and Savings Account Statements - Proof of out of pocket medical bills - Copy of Medicaid Card or Denial Letter (if applicable) - Documentation of bankruptcy or catastrophic situation, such as death in family**

**METROLINA ASSOCIATION FOR THE BLIND**

**STATEMENT OF NO INCOME**

If you have **NO** monthly income, please read and sign the following statement:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do not currently have any income, which includes but is not limited to wages, unemployment benefits, disability benefits, self-employment income, Social Security and retirement. I understand that it is my responsibility to report to Metrolina Association For The Blind at the start of any income within 10 days of its beginnings. IF YOU HAVE NO INCOME PLEASE TELL US HOW YOUR HOUSEHOLD BILLS ARE PAID. IF ANOTHER PERSON PAYS THE BILLS, PLEASE PROVIDE A SIGNED LETTER OF SUPPORT.

By signing this document I am agreeing that all the information is true and accurate to the best of my knowledge.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**METROLINA ASSOCIATION FOR THE BLIND**

**LETTER OF SUPPORT**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of person providing support), provide support in the following way (circle all that apply):

pay rent pay utilities provide housing other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of person being supported).

***I am not financially responsible for his/her bills****.* I provide support in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per month (dollar value of support).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Printed Name Relatiionship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address Phone Number

**\*IF MORE THAN ONE PERSON IS SUPPORTING YOU, A LETTER OF SUPPORT IS NEEDED FROM EACH ONE.**