Family Wellness
FINANCIAL AID Request Form

New Application ☐

Renewal ☐

Section 1

Primary Applicant Name:________________________ All Faiths Client? Yes ☐ No ☐

Birthdate:________________________ Social Security Number:________________________

Other Name(s) used in the last 10 years?________________________

Address:________________________ How long?____________

Primary Phone Number:________________________ Email address:________________________

Marital Status: Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐

Spouse Name:________________________ Spouse Birthdate:________________________

Can someone claim you as a dependent? Yes ☐ No ☐ If yes, Who?________________________

Section 2

Please list Names and Birthdates of your dependents below:

1. Name:________________________ Birthdate:____________ All Faiths Client? Yes ☐ No ☐
   Are you a legal guardian? Yes ☐ No ☐ Custody: Full ☐ Foster ☐ Joint ☐ Visitation ☐ Grandparent ☐
   Does this person live in your home? Yes ☐ No ☐ Does this person help w/household expenses? Yes ☐ No ☐

2. Name:________________________ Birthdate:____________ All Faiths Client? Yes ☐ No ☐
   Are you a legal guardian? Yes ☐ No ☐ Custody: Full ☐ Foster ☐ Joint ☐ Visitation ☐ Grandparent ☐
   Does this person live in your home? Yes ☐ No ☐ Does this person help w/household expenses? Yes ☐ No ☐

3. Name:________________________ Birthdate:____________ All Faiths Client? Yes ☐ No ☐
   Are you a legal guardian? Yes ☐ No ☐ Custody: Full ☐ Foster ☐ Joint ☐ Visitation ☐ Grandparent ☐
   Does this person live in your home? Yes ☐ No ☐ Does this person help w/household expenses? Yes ☐ No ☐

4. Name:________________________ Birthdate:____________ All Faiths Client? Yes ☐ No ☐
   Are you a legal guardian? Yes ☐ No ☐ Custody: Full ☐ Foster ☐ Joint ☐ Visitation ☐ Grandparent ☐
   Does this person live in your home? Yes ☐ No ☐ Does this person help w/household expenses? Yes ☐ No ☐

5. Name:________________________ Birthdate:____________ All Faiths Client? Yes ☐ No ☐
   Are you a legal guardian? Yes ☐ No ☐ Custody: Full ☐ Foster ☐ Joint ☐ Visitation ☐ Grandparent ☐
   Does this person live in your home? Yes ☐ No ☐ Does this person help w/household expenses? Yes ☐ No ☐

6. Name:________________________ Birthdate:____________ All Faiths Client? Yes ☐ No ☐
   Are you a legal guardian? Yes ☐ No ☐ Custody: Full ☐ Foster ☐ Joint ☐ Visitation ☐ Grandparent ☐
   Does this person live in your home? Yes ☐ No ☐ Does this person help w/household expenses? Yes ☐ No ☐

Is CYFD/Law Enforcement/Court Clinic involved with you or your children/dependents? Yes ☐ No ☐

Questions? Please call 505-271-0329 or email FWFA@allfaiths.org

Section 3

Are you: Employed ☐ Unemployed ☐ Student ☐ Salary or hourly rate: $____________________________

Spouse/Domestic Partner: Employed ☐ Unemployed ☐ Salary or hourly rate: $__________________________

Your Employer and Position:____ How long:_______________

If you receive Financial Aid from loans or family members, how much/often: $_________________ per________________

Amount and Frequency of child support payments: $_________________ per________ Do you: Pay ☐ Receive ☐

Do you or one of your dependents receive SSA? Yes ☐ No ☐ Amount per month? $______________________

Do you or one of your dependents receive SSI? Yes ☐ No ☐ Amount per month? $______________________

If you are not able to provide proof of income, please estimate how much each working member of the household makes per week (including tips): You $__________________________ Your Spouse $___________________________

Do you have income from any other sources (rentals or retirement)? Amount per month? $______________________

Annual Household Income before taxes (for all adults in home): $____

Section 4

Do you have Health Insurance? Yes ☐ No ☐ Insurance Carrier:_____________________________________

Name and Date of Birth of Primary Member (If not you)____

Insurance ID number:______________________________________ Office Visit Copay: $____________________

What is your yearly deductible? $_________________________ Has your deductible been met? Yes ☐ No ☐

Is All Faiths (and the clinician you see) In-Network with your insurance? Yes ☐ No ☐ Unknown ☐

Section 5

Are you eligible for Public Benefits such as Medicaid? Yes ☐ No ☐ Pending ☐

Do you have Medicaid? Yes ☐ No ☐ Family Planning Only ☐ Medicare Copays Only ☐

Do your dependents have Medicaid? Yes ☐ No ☐ Not Applicable ☐

Do you receive assistance for: Housing ☐ Food/Snap ☐ Water/Utilities ☐ Cash ☐

Section 6

Have you or your dependent(s) been the victim of a crime? Yes ☐ No ☐

Have you applied for VOCA (Crime Victims Reparation Commission)? Yes ☐ No ☐ Not Applicable ☐

Section 7

Additional information you would like us to take into consideration: ____________________________________

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By signing below, you certify that all information provided in this application is correct and accurate to the best of your ability.

Print your name: ____

Signature: ____ Date: ____________________

Family Wellness FINANCIAL AID Application Instructions

In order to process your application, we must receive the following documentation:

1. Proof of monthly income may be provided in the following ways:
   - ☐ 2 most recent pay check stubs from your employer
   - ☐ 2 most recent pay check stubs from your spouse's/partner's employer (if applicable)
   - ☐ Other proof of income such as SSI statements or bank statements
   - ☐ Letter from Employer listing how much is made per week (only if pay stubs not available).
2. Proof of yearly household income and number of dependents:
   - ☐ May through December - most recent year's completed tax return
   - ☐ January through April - previous year's completed tax return along with current W2(s).
3. Proof of Identification:
   - ☐ Driver's License, Passport, School ID, etc. (must have picture)
4. Proof of Insurance coverage:
   - ☐ Insurance ID or Letter from Insurance company confirming coverage (if not on file)

If you are not able to provide the above documentation, please tell us why: ______________________________

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Additional documentation may be emailed to FWFA@allfaiths.org

Finance Use Only

Date Received:____________________ Date Documents Received:______________________________

Approved ☐ Denied ☐ Coverage level: ________________ Expiration:____________________________

If Denied, why?____

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Notes:____

____

Processed by:____________________ Signature:____________________ Date: ____________________

Questions? Please call 505-271-0329 or email FWFA@allfaiths.org

General Information:

- Financial assistance is available through grant funding from our community partners. Funding is limited therefore we moderate its use for families who need it the most.
- Citizenship or residency status does NOT affect your application or eligibility.
- Assistance is determined by your household income and family size. We use a sliding scale to determine your level of coverage. It may be anywhere from 10 to 100%.
- Applicants over the age of 18 who do not have dependents may only apply under special circumstances.
- Assistance may be used to cover your out-of-pocket expenses such as commercial insurance copays and deductibles. Assistance may only be applied to out-of-pocket expenses after your insurance has been billed.
- Completed applications may be returned to the Front Desk or mailed to the Finance Department at:
  1709 Moon St NE, Attn: Finance Department, Albuquerque, NM 87112 or emailed to FWFA@allfaiths.org
- Incomplete applications will not be processed. However, All Faiths understands that special circumstances may prevent you from providing all requested documentation. These circumstances should be documented on your application.
- Questions regarding coverage should be directed to our Finance Department at 505-271-0329.
- Applications typically take 7-10 days to process. Clients will be contacted after processing is complete.
- All information and documentation provided will be kept confidential.
- Assistance may be backdated up to 6 months.

Instructions

- Section 1 – Demographics
  - Full name, birthdate and social security number of the primary applicant is required.
  - If you are over 18 but still in school or living with your parent(s) or guardian, please check the box noting that you are considered a dependent. Please list their annual income as well as your own, in section 3.
- Section 2 – Dependents
  - Please list all dependents living in your household. Grandchildren should be included if you are their main source of support.
  - Adult children who are students should be listed if you are supporting them.
- Section 3 – Employment and Income
  - Applications will be considered incomplete if spouse or domestic partner income is not listed.
- Section 4 – Insurance coverage
  - All insurance information must be provided so that we can maximize your coverage options for you.
  - Our network status with your insurance carrier will not affect your eligibility.
- Section 5 – Public Benefits
  - Public assistance such as Housing, Energy, WIC or SNAP will not affect your eligibility for financial assistance.
  - Student Loan information will be factored into your finances but will not affect your eligibility.
- Section 6 – Victims of Crime
  - The Crime Victims Reparation Commission is a useful financial support tool for those who qualify. If you think you or your dependent might qualify, please ask the Front Desk for a CVRC/VOCA questionnaire and application.
  - If you qualify for CVRC/VOCA assistance, this funding will be utilized before our Family Wellness assistance funding.
- Section 7 – Additional Information
  - Please list any special circumstances that you think might affect your application.
- Section 8 – Documentation
  - Applications will not be processed if documentation is missing or incomplete.
  - If pay stubs and/or tax information is not available, other documentation will be accepted on a case-by-case basis.
  - If you cannot provide all the requested documentation, please explain why in this section.