

Sonia Plotnick Health Fund

Application for Financial Assistance

To receive financial assistance from the Sonia Plotnick Health Fund (SPHF), You must be a permanent female resident of Pinellas, Hillsborough, Manatee Pasco, or Sarasota Counties and not have the financial resources to meet your healthcare needs.

Do you meet criteria? Yes No Have you applied before? Yes No
If yes When

If you do not meet criteria and want the board to consider you as an exception, please submit this form along with any explanatory information.

The Board meets monthly and your application will be anonymous to all board members except the administer and will be handled confidentially. Upon approval, we will disburse funds directly to your healthcare provider. We will need your consent to contact your provider. Alternatives to traditional medicine, such as chiropractic, homeopathy, and acupuncture are considered valid requests. Health insurance does not eliminate you from receiving funds.

<u>Applicant Information</u>		Click on column	
Name F/M/L	Address	Telephone(s) W/H	E-mail

Do you want to receive e-mail from us: yes no

Best time to be reached: Last 4 digits of Social Security # _____

How did you hear about us? Date of Birth _____

Financial request Information* Please provide a copy of all Bills and Provider Information
*** No amount is guaranteed by application, funds are dependent on availability and approval.**
 Short Description of Request: Amount requested:

Click on box

Consent to contact your Provider Yes No Health Insurance Yes No
 If yes for insurance: Co pay amt Deductible amt Prescription co pay
 Car Accident? Deductible amt
 Mail to: SPHF E-mail form and scanned bills to: soniaplotnick@ yahoo.com
 P.O. Box 530606 fax # pending
 St. Petersburg,Fl. 33747

Questions? Contact us @ 727 482-0216

For SPHF use: Approval	Denial	Applicant #
Amount approved	Date of Disbursement	Check #