

# STRMU Financial Assistance Request

Attachment 27

Client ID: \_\_\_\_\_

Date of Request: \_\_\_\_\_

**Circumstances of Request:**

**Case Manager Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider Verification (for medication requests only):**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For HOPWA Requests only:**

Income Eligibility on file?  Yes  NO Household Size: \_\_\_\_\_

AMI for Household: \_\_\_\_\_ (Monthly x12) \_\_\_\_\_ (annual)

Established 80% of AMI \_\_\_\_\_ for \_\_\_\_\_ County

HOPWA Case Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Case Manager has obtained documents of income for each individual that comprises the household that is requesting financial assistance and certifies that this individual or household is at or below the 80% Area Median Income Guidelines for the county of residence.*

**\*By submitting this form the case manager attests that the client is RW eligible and declares there are no other funding sources to assist client with payment; making RW the payer of last resort.**

Funds to be issued as follows:

1. Name: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Address: \_\_\_\_\_ Payer Source: \_\_\_\_\_  
\_\_\_\_\_

2. Name: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Address: \_\_\_\_\_ Payer Source: \_\_\_\_\_  
\_\_\_\_\_

3. Name: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Address: \_\_\_\_\_ Payer Source: \_\_\_\_\_  
\_\_\_\_\_

Notes: \_\_\_\_\_

Director Signature of Approval: \_\_\_\_\_ Date: \_\_\_\_\_

***Copies of all payments must be attached to request and filed in client case management file***