Application form for financial support

1 Details of the person concerned (patient)

Family name/given name(s): _____

Gender: ☐ female ☐ male ☐ divers Nationality: _____

Date of birth (DD.MM.YYYY): _____ Country/place of birth: _____

Age: _____ Profession: _____ ___

Address: _____

E-Mail: _____ Phone: _____

2 Details of persons living in the same household (parents, husband, siblings, children, etc.)

Family name/given name(s)	Date of birth	School/Education/Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3 Economic necessity: Monthly net income of all persons belonging to the household

(wage/salary, pension, social benefits, child benefit ..)

	person concerned	husband/ partner	parents	children	other persons
Income per month	_____ €	_____ €	_____ €	_____ €	_____ €

Total amount _____ **€**

4 Extraordinary (medical) expenses per year …

for _____ _____ €

for _____ _____ €

5 We, the hospital _____ confirm that the person concerned or his/her family is in financial need.

Date: _____ _____

(Signature of the hospital)

Alternatively, a confirmation from an authority can be attached.

6 Diagnosis and planned treatment

7 Contact details of the hospital and the responsible doctor (name/location/email):

8 ☐ Application is approved

Date: _____ _____
(Signature of the hospital)

Please submit the application with 2 good pre-operative and 2 good post-operative photos of the patient in high quality (at least 1 MB in size, preferably smiling, full face).

Please note: In the case of cataract surgery, further information is required. Please contact us in this case: www.help-wirhelfen.de

Declaration of financing the medical treatment

I hereby declare that the requested amount of financial support is not exceeding the total costs of the treatment. The estimated medical costs are enclosed. I assure that the indicated information is correct and given to my best knowledge and belief.

Date: _____ _____

(Signature of the patient or in case of minors of the parents or legal guardian)

Consent and declaration to the release of documents and photos

I,

_____

(patient's name or name of parents or legal guardian in case of minors)

hereby give „Help! – Wir helfen! e.V." the absolute and irrevocable right and permission, with respect to the photos, radiographs and patient's details etc. taken or given of me / respectively the patient by Help! – Wir helfen! e.V. respectively herewith entrusted persons (hospital employees/doctors etc.) or which I have handed over to them, to use them as follows:

a) To copyright the same under its own name or any other name it may choose.

b) To reuse the same in whole or in any part, individually or in connection with other photos in any medium (printed media, in the web etc.) for illustration, promotion/advertising and publication purposes of information, however, without being limited to it. I agree that my name is used in publications of all kinds.

c) To hand over the photos taken by me and the personal details for review to third parties – also electronically – and to memorize them electronically.
I hereby waive and discharge Help! – Wir helfen! e.V. and the persons having taken the photos and generated the report and using them in the name of Help! – Wir helfen! for association purposes from any and all claims and demands arising thereof. I shall release the photos and reports for the use of Help! – Wir helfen! e.V. This also applies to photos and reports having been taken and generated by other institutions (doctors/hospitals etc.), as for example radiographs and/or ultrasonic images etc.
I have read and completely understood the contents of this declaration.

_____

(Place and date)

_____ _____

(Name in printed letters) (Signature of the patient or legal guardian in case of minors)