THE BEN EYESTONE FUND

Request for Assistance Application

The Ben Eyestone Fund, a joint venture between Music Health Alliance and Saint Thomas Health, will provide a menu of services for diagnostic healthcare. The fund will serve working un-insured or under-insured music industry professionals in Davidson and surrounding counties within Middle Tennessee earning an adjusted gross income under 300% above the Federal Poverty Level who show an obvious diagnostic need.

Please complete application and return to Music Health Alliance by emailing to info@musichealthalliance.com or call 615-200-6896 to schedule a meeting with one of our advocates to discuss next steps.

Legal Name: _____ Professional Name: _____

Home Address: _____

_____

Cell Number: _____ Date of Birth: _____/_____/_____ SSN: _____ ____ _____

Email Address: _____ Marital Status ____M ____ S ____D

Spouse's Name: _____ Is spouse Employed? ____ Yes _____ No

Any Dependents?_____ Yes _____No If yes, ages: _____ _____ _____ _____ _____ _____ _____ _____

Who referred you to Music Health Alliance? _____

PROFESSIONAL CAREER HISTORY:

Please describe your career in music industry (*or attach discography/bio):* _____

_____

_____

_____

Have you been assisted by other industry foundations? ____ Yes ____ No. If yes, what organizations & amounts?

_____

_____

Please answer the following financial and health questions:

□ Do you currently have health insurance? ___ yes ___ no. If yes, what is your deductible? _____

□ Do you currently have a Primary Care physician? ___ yes ___ no. If yes, who? _____

□ Have you seen *any* physician or clinic for your symptoms? ___ yes ___ no. If yes, who and when?

_____

_____

_____

□ Please explain the symptoms you are experiencing. _____

_____

_____

_____

_____

_____

_____

□ Type of test/visit being requested: _____

_____

_____

_____

_____

Please provide the following financial documents to support application:

- A copy of your most recent tax return (if self-employed, please include ALL schedules.)
- Copies of your 3 most recent pay stubs showing total earnings (before taxes).
- Copy of Social Security, Pension/Retirement Award Letter OR Bank Statement showing Social Security, Pension/Retirement Deposit OR Copy of most recent Social security, Pension/Retirement Check –OR-
- All students ages 25 and younger must supply copies of their parent's most recent tax return if they are listed as dependents n their parent's taxes.

I hereby certify that I have answered the forgoing questions to the best of my ability. The facts herein stated are true and I understand that any misrepresentation of this information may disqualify me for any assistance from Music Health Alliance.

Signature of Applicant: _____ Date: _____

To the best of my knowledge, I certify that the information provided is true

MHA Advocate Requesting Assistance: _____ Date: _____

MONTHLY INCOME & EXPENSES

MONTHLY BUDGET FORM

INCOME:		EXPENSES:	
Income From Work	$	Rent/Mortgage	$
Residuals & Royalties	$	Second Mortgage	$
Unemployment Benefits	$	Groceries	$
Social Security Income	$	Maintenance	$
		Home Owner's	
Social Security Disability	$	Association Fee	$
SSI *(Supplemental)* General Relief	$	Food	$
Food Stamps	$	**UTILITIES:**	$
Veteran Benefit	$	Gas	$
Spouse/Partner's Income	$	Electric	$
Alimony	$	Water/Sewer/Garbage	$
Child Support	$	Telephone/Fax	$
Union Pension(s)	$	Cell Phone	$
Fund/Interest	$	**TRANSPORTATION:**	
		Car Payment	$
OTHER INCOME:		Car Insurance	$
(Financial assistance from family & friends)		Gasoline	$
	$	Public Transit	$
	$	**MEDICAL/DENTAL:**	
		Health Insurance	$
Relief Grant(s)*(specify)*		Medical Bills	$
	$	Prescriptions	$
	$	Dental Bills	$
		MISCELLANEOUS	
	$	**EXPENSES:**	
		Life Insurance	$
TOTAL INCOME:	$	Union Dues	$
		Loan(s)	$
ASSETS:		Credit Card(s)	$
Checking Account	$		$
Other Accounts:	$		$
	$	Alimony Payments	$
		Child Support	
	$	Payments	$
Real Estate *(if applicable)*		Laundry/Cleaning	$
Purchase Price		OTHER: *(list)*:	
Present Value			$
TOTAL ASSETS:	$	**TOTAL EXPENSES:**	$

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