



Gilbert Health Foundation

Financial Assistance Application Form

Personal Information:

Name: _____
Date of Birth: _____
Address: _____
City: _____ State/province: _____
ZIP/postal Code: _____
Email Address: _____
Phone Number: _____

Household Information:

Household Size: _____ (Include yourself and dependents)

Total Annual Household Income: \$ _____

Monthly Expenses:

- Rent/Mortgage: \$ _____
- Utilities (Electricity, Gas, Water, etc.): \$ _____
- Food/Groceries: \$ _____
- Transportation (Car payment, Gas, Public Transit, etc.): \$ _____
- Health Insurance: \$ _____
- Other (Childcare, Loans, etc.): \$ _____
- Total Monthly Expenses: \$ _____

Financial Assistance Request:

Please describe the specific financial assistance you are requesting and the reason for your request. Include any supporting documentation (e.g., medical bills, rent notices, etc.):

Declaration:

I hereby declare that the information provided on this application is true and accurate to the best of my knowledge. I understand that any false information may result in the denial of financial assistance. I authorize Gilbert Health Foundation to verify the information provided.

Applicant's Signature: _____ Date: _____

Submission Instructions:

Please submit your completed application form along with all required supporting documentation to financialassistance@gilberthealthfoundation.org.

Gilbert Health Foundation

Gilberthealthfoundation.org

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