Hope Is Where the Heart Is
RenéMarie Language of Love Foundation INC
501(c)(3), nonprofit Organization
B.E.F.A.S.T

RenéMarie's Language of Love Foundation Inc.

Stroke & Aphasia Advocacy
973-985-0420

Money should not be the determining factor in recovery.

Financial Support Should Not Be a Barrier to Recovery

We accept applications on Financial Assistance to eligible individuals in the New Jersey area who meet the following criteria:

- The applicant must provide proof of U.S. citizenship and legal residency in New Jersey.
- The applicant must have a doctor's diagnosis of Stroke or Aphasia.
- The applicant must submit an Explanation of Benefits (EOB) for the current year, showing that insurance coverage for Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), or Music Therapy has been exhausted.
- The applicant must have a referral from a medical therapist, confirming a continued need for PT, OT, SLP, or Music Therapy for ongoing improvement.
- The applicant must demonstrate a legitimate personal financial hardship preventing the ability to afford additional necessary therapy.
- The applicant must express a commitment to continue with their therapy and recovery process.

Levels: $250.00, $500.00 & $1000.00 - The amount is determined by the organization.

Disclaimer: RenéMarie's Language of Love Foundation Inc. is a nonprofit organization committed to supporting individuals impacted by Stroke and Aphasia through advocacy, educational initiatives, and financial assistance. The Foundation aims to provide vital resources and support to those in need, with all aid subject to eligibility requirements, availability of funds, and the specific needs of the applicants.

Financial assistance is granted at the discretion of the Foundation and is primarily intended to assist individuals whose insurance coverage has been exhausted. The Foundation believes that financial constraints should not be a barrier to recovery. All decisions regarding financial aid are final, and RenéMarie's Language of Love Foundation Inc. reserves the right to amend, adjust, or discontinue any program at its discretion.

By applying for financial assistance, applicants acknowledge that the Foundation is not liable for any direct or indirect consequences arising from the aid or advocacy provided.

FINANCIAL ASSISTANCE FORM **Goes into effect 2-1-2025**

APPLICANT NAME:_____ DATE OF BIRTH: _____

ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____

COUNTY OF RESIDENCE: _____ ARE YOU A U.S. CITIZEN?_____

CONTACT PHONE NUMBER:_____ EMAIL ADDRESS: _____

Self-identification information allows The RenéMarie Language of Love Foundation Inc.~ Stroke and Aphasia Advocate to collect valuable statistical information. The information in NO way determines financial assistance eligibility.

GENDER: ☐ MALE ☐ FEMALE RACE: _____

HOW DID YOU LEARN ABOUT The RenéMarie Language of Love Foundation Inc? _____

MEDICAL DIAGNOSIS: TYPE OF STROKE OR CAUSE OF APHASIA?

DATE YOU WERE DIAGNOSED _____

WHAT HOSPITAL AND/OR OTHER MEDICAL FACILITIES HAVE YOU RECEIVED TREATMENT FOR YOUR INJURY?

PLEASE LIST NAME, TYPE OF TREATMENT AND DATES. **Example**: Language of Love Recovery Center – *outpatient rehabilitation* – Musical and Physical Therapy – April 8, 2024 - . May 21st 2024

FACILITY	TREATMENT	DATES
FACILITY	TREATMENT	DATES
FACILITY	TREATMENT	DATES
FACILITY	TREATMENT	DATES

SELECT ALL THAT APPLY:

- ☐ EMPLOYED
- ☐ UNEMPLOYED - RECEIVING ASSISTANCE
- ☐ UNEMPLOYED - NO FINANCIAL ASSISTANCE
- ☐ RECEIVING DISABILITY

DO YOU HAVE HEALTH INSURANCE? _____ INSURANCE PROVIDER: _____

HAVE YOU APPLIED FOR MEDICAL ASSISTANCE IN THE PAST 6 MONTHS: _____

IF YES, PLEASE EXPLAIN: _____

ARE YOU ELIGIBLE OR DO YOU CURRENTLY RECEIVE MEDICARE, MEDICAID OR OTHER GOVERNMENT ASSISTANCE?_____ TYPE OF ASSISTANCE: _____

HAVE YOU BEEN ASSISTED BY The RenéMarie Language of Love Foundation Inc.~ Stroke and Aphasia Advocate IN THE PAST?_____ IF YES, WHEN? _____

PLEASE INCLUDE ANY OTHER FINANCIAL ASSISTANCE RECEIVED FROM ANY OTHER AGENCIES OR INDIVIDUALS.

FINANCIAL ASSISTANCE FORM

MARITAL STATUS: Circle One

_____MARRIED
_____WIDOWED
_____DIVORCED
_____SINGLE

IF MARRIED, NAME OF SPOUSE: _____

SPOUSE'S EMPLOYER: _____

_____

LAST YEAR TAX RETURN WAS FILED:_____TOTAL NUMBER OF HOUSEHOLD MEMBERS AS LISTED ON YOUR IRS FORM 1040. _____ _____

YOU WILL BE REQUIRED TO PROVIDE YOUR LAST YEAR'S INCOME TAX RETURN WITH YOUR APPLICATION.

REASON YOU ARE REQUESTING FINANCIAL ASSISTANCE FROM The RenéMarie Language of Love Foundation Inc.~ Stroke and Aphasia Advocate**:** _____

_____

_____

_____

_____

DOCUMENTATION REQUIRED TO ACCOMPANY THIS APPLICATION: ***Please include copies of documents and NOT originals as they will not be returned.***

COPY OF PROOF OF US CITIZENSHIP (US Passport, Birth Certificate, Certificate of Citizenship, etc.)
COPY OF PROOF OF NORTH CAROLINA RESIDENCY (Valid Drivers License, Utility Bill, Voter Registration,
etc.) COPY OF MOST RECENT INCOME TAX RETURN
COPY OF MOST RECENT MEDICAL INSURANCE EXPLANATION OF BENEFITS
MEDICAL PHYSICIAN OR THERAPIST REFERRAL LETTER FOR CONTINUED NEED OF PHYSICAL, OCCUPATIONAL AND/OR SPEECH THERAPY

ONCE YOUR APPLICATION HAS BEEN REVIEWED, YOU MAY BE CALLED FOR AN INTERVIEW BEFORE A FINAL DECISION IS MADE.

FINANCIAL ASSISTANCE FORM DISCLAIMER:

I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE USED TO DETERMINE FINANCIAL SUPPORT ELIGIBILITY, The RenéMarie Language of Love Foundation Inc: Stroke and Aphasia Advocate. ALL THE INFORMATION WILL BE KEPT CONFIDENTIAL. I UNDERSTAND THAT THE DOCUMENTS I SEND TO PROVE MY ELIGIBILITY MAY NOT BE RETURNED. I FURTHER UNDERSTAND THAT THE INFORMATION I AM SUBMITTING IS SUBJECT TO VERIFICATION BY The RenéMarie Language of Love Foundation Inc.~ Stroke and Aphasia Advocate. I UNDERSTAND IF ANY INFORMATION PROVIDED IS DETERMINED TO BE FALSE OR INCOMPLETE, IT CAN RESULT IN AUTOMATIC DISQUALIFICATION FOR FINANCIAL ASSISTANCE. ALL CLIENT INFORMATION IS KEPT CONFIDENTIAL AND ALLOWS The RenéMarie Language of Love Foundation Inc.~ Stroke and Aphasia Advocate TO COLLECT AND MAINTAIN ACCURATE DATA FOR STATISTICAL AND ACCOUNTABILITY PURPOSES.

MY SIGNATURE AUTHORIZES The RenéMarie Language of Love Foundation Inc: Stroke and Aphasia Advocate TO VERIFY ALL INFORMATION PROVIDED ON THIS FORM. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HAVE ALSO READ AND CAREFULLY UNDERSTAND BOTH THE DISCLAIMER AND PURPOSE OF *The RenéMarie Language of Love Foundation Inc.* MAINTAINING MY INFORMATION IN A CONFIDENTIAL MANNER.

APPLICANT SIGNATURE: _____DATE:_____

If the applicant requires assistance with the application, please provide the name of the person filling out the application, relationship, and contact number:

PRINT THE NAME AND SIGNATURE OF THE PERSON FILLING OUT THE FORM ON BEHALF OF THE APPLICANT:_____

RELATIONSHIP TO APPLICANT:_____ CONTACT NUMBER: _____

Thank you for your interest in ****YOU WILL BE REQUIRED TO PROVIDE YOUR LAST YEAR'S INCOME TAX RETURN WITH YOUR APPLICATION.

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"We will contact you regarding your application as soon as possible. In the meantime, we wish you all the best on your path to recovery."

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