Sonia Plotnick Health Fund

Application for Financial Assistance

To receive financial assistance from the Sonia Plotnick Health Fund (SPHF),
You must be a permanent resident of Pinellas, Hillsborough, Manatee or Sarasota Counties and you must be a womyn.

Do you meet criteria? Yes No

If you do not meet criteria and want the board to consider you as an exception, please submit this form along with any explanatory information.

The Board meets monthly and your application will be anonymous to all board members except the administer and will be handled confidentially. Upon approval, we will disburse funds directly to your healthcare provider. We will need your consent to contact your provider. Alternatives to traditional medicine, such as chiropractic, homeopathy, and acupuncture are considered valid requests. Health insurance does not eliminate you from receiving funds.

Applicant Information Click on column

Name F/M/L	**Address**	Telephone(s) W/H	E-mail

Best time to be reached:

How did you hear about us?

Financial request Information* **Please provide a copy of all Bills and Provider Information**
* **No amount is guaranteed by application, funds are dependent on availability and approval.**
Short Description of request:

Consent to contact your Provider Yes No Health Insurance Yes No
If yes for insurance: Co pay amt Deductible amt Prescription co pay
Car Accident? Deductible amt
Mail to: SPHF
P.O. Box 530606
St. Petersburg,Fl. 33747

E-mail form and scanned bills to: soniaplotinick@ yahoo.com
fax # pending

Questions? Contact us @ 727-482-0216

For SPHF use: Approval Denial
Amount approved Date of Disbursement Check #