TANNER FOUNDATION
FOR NEUROLOGICAL DISEASES

Patient Assistance Fund

Application Date:_____

Applicant Name (Patient): _____

Primary Caregiver Name: _____

Insurance (Check all that apply)

___ Private Insurance, what type?_____
___Medicare (Part B)
___Medicaid
___Veterans Benefits ___ YES ____NO

Phone (Home):_____Cell: _____Work:_____

Address: _____City/State/Zip_____

Email: _____

Neurological Diagnosis: _____

******Please note a diagnosis letter from a doctor must accompany all applications********

Number of persons living in household:_____ How many children: _____

Annual Household income:_____ Monthly expenses:_____

Are you financially able to meet your monthly expenses? ____ YES ____NO

Alternative Resources explored:_____

PROGRAM YOU ARE APPLYING FOR: (Fill out amount requested for which service you are applying for and then describe request)

Type of Service	Amount Requested

Respite Care _____

Nutrition Consultation _____

Wellness Consultation _____

Counseling Services _____

Activites of Daily Living items (ADL) _____

Accessibility Grant _____

Travel _____

FOR FOUNDATION USE ONLY

DATE APPLICATION RECEIVED:_____DATE DIAGNOSIS LETTER RECEIVED:_____

APPROVED: _____YES_____NO.
DATE PATIENT/CAREGIVER NOTIFIED OF APPROVAL:_____

BOARD APPROVAL SIGNATURES:

1._____

2. _____

3. _____

4. _____

5. _____

NOTE REGARDING REQUEST APPROVAL OR DENIAL: _____

_____