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
PT/OT consultation and treatment	_______________
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: ___________________________________

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