CSC Family Assistance Application

Patient Information:

Patient's Name _____Age: _____ Male/Female: _____

Address_____

City_____ State _____ Zip Code _____

Phone: _____

Email: _____

Guardian Information: (If patient is a minor)

Name _____ Relationship to Patient _____

Address_____

City_____ State _____ Zip Code _____

Phone: _____

Email: _____

Medical Information:

Treating Hospital: _____ Doctor: _____

Family Information:

Family Size _____

The information requested is necessary to process your application. You may be asked by the Cloves Syndrome Community Board for additional information to determine your eligibility for financial assistance. All information provided will be reviewed only by the Board and will remain strictly confidential.

Reason for Financial Assistance Request: (Please explain how the funds requested will be used.)

_____

_____

_____

Amount of Financial Assistance Requested: _____

Applicant Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Disclaimer: Cloves Syndrome Community is a 501c3 non-profit organization and does not discriminate against age, gender, color, race, disability or religion.

Any questions, please contact clovessyndrome@gmail.com or 207-281-2130.

Please return the completed application along with any supporting documents to the address or email listed below.

PO BOX 406, WEST KENNEBUNK, ME 04094 PHONE: 207.281.2130
WWW.CLOVESSYNDROME.ORG
CLOVESSYNDROME@GMAIL.COM