We Serve the Following Counties:
Carroll, Douglas, Haralson, & Heard

501(c)3 non-profit corporation

APPLICATION FOR ASSISTANCE

THIS FORM IS FOR INDVIDUDALS THAT APPLY FOR FINANCIAL ASSISTANCE. YOUR FULL COOPERATION IN SUPPLYING ALL OF THE INFORMATION REQUESTED IS NECESSARY FOR OUR RECORDS. THANK YOU.

Date of Application: _____

Name of Applicant: [Print] _____

Address: _____

Home Phone: _____ Cell Phone: _____

Type of Assistance: Payment _____ Prescription _____ Supplies _____

Reason for Assistance:

_____

_____

_____

_____

Amount Applyfing For: $_____

Hospital/Physician's Name: _____

Diagnosis: _____

Telephone Number: _____ Appointment Time: _____

Pharmacy's Name & Number: _____

Signature of Applicant: _____

FOR OFFICE USE ONLY

Aproved: _____ Diapproved: _____

Reason:

_____

_____

_____

_____

_____