

Clinic of Angels

Application for Services

Please print clearly. None of the information will be returned so please make a copy for your records. Thank you in advance.

Your Name _____

Phone _____ E-mail _____

Home Address _____ City _____ State _____ Zip _____

Business _____ Title _____

Criteria

All information must be completed and submitted at the same time for consideration. While the Board of Directors of the Clinic of Angels would like to support all those in need and grant financial aid, it is limited to available resources and may be discontinued or revised at any time.

1. Patient must be a U.S. citizen or permanent resident. ____ Yes ____ No
2. Patient must claim lack of insurance coverage and/or insurance denial. (It is important that you attach a copy of your letter of denial.)
3. Patient must be treated on an outpatient basis.
4. A letter from your medical professional stating your prognosis is required.
5. The patient must provide the last two year's tax returns of the total household income filed with the IRS. (Please attach.)
6. Patient's total household income (the combined income of the patient and/or significant other) must be below the Clinic's Poverty Level. (See chart on next page.) If you do not meet this criteria, and feel you have extenuating circumstances, please use the space provided on the next sheet to give additional information.
7. The patient and/or guardian must sign and date this application.
8. Patient assistance for 25-100% will be provided up to \$5,000 and/or six months. At such time, the Application Screening Committee will ask for updated information to reestablish the need for additional funds up to \$3,000.
9. The Application Screening Committee would like to know: 1) What you've been experiencing with your health challenges, and 2) Why should they choose you for these services. (Please attach a detailed letter.)

Providing financial assistance for treatment of the following diseases: Lyme Disease; Neurological Illness; Chronic Fatigue Syndrome; Fibromyalgia Syndrome; ALS (Lou Gehrig's Disease); Multiple Sclerosis.

Treatments not covered: The following is a list of therapies that we will not cover: Accupuncture, Chelation, Ozone, Hyperbaric, Rife, Heat or Shock Treatments, Hydrogen Peroxide Injections, Vitamin or Nutritional Supplements, and the like. We also will not provide the funds for palliative care.

Your signature _____ Date _____

TREATMENTS NOT COVERED

The following is a list of therapies that we will not cover: Acupuncture, Chelation, Ozone, Hyperbaric, Rife, Heat or Shock treatments, Hydrogen Peroxide Injections, Vitamin or Nutritional Supplements, No funds provided for Palliative Care. However, the Review Committee reserves the right to change this list at anytime.

PLAN OF TREATMENT

Date _____

Physician Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Name _____

Date of Birth _____

Diagnosis _____

Treatment Orders:

- _____
- _____
- _____
- _____

Approximate Length of Therapy:

Physician Signature _____

Official Use Only

Reviewed by Committee _____

Date _____

Accepted _____ Pending _____ Rejected _____

Please mail the completed form and all necessary papers to:

The Clinic of Angels
9804 n. 56th Street
Tampa, FL 33617

Phone: 813-980-1236
Fax: 813-989-3777