



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 () _____ Email _____
 Home Address _____ City _____ Zip _____
 Business _____ Title _____
 Business Address _____ City _____ Zip _____

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, this new program at this time is limited, though growing, in resources. 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. (Please attach the letter of denial which is required.)
3. Patient must be treated on an outpatient basis.
4. Patient's total household income (the combined income of the patient and/or significant other) must be below the Clinic's Poverty Level. 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.
5. The patient must provide the last two years of tax returns of the total household income filed with the IRS. (Please attach.)
6. The patient and/or guardian are asked to please sign and date this application.
7. Patient assistance for 25-100% will be provided for up to six months. At such time, the Application Screening Committee will ask for updated information to reestablish the need for additional funds.
8. 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.)

Your signature _____ Date _____

Reviewed by Committee _____ Date Accepted Pending Rejected

**Please mail this to
Doloras Perrone, c/o Clinic of Angels,**