

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 _____
Daytime Cell Phone _____
Home Address _____ City _____ State _____ Zip _____
Employer _____ 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. Please do not send an incomplete application.

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. Have you applied for Medicare ____ Yes ____ No. Medicaid ____ Yes ____ No. If yes, when or how long have you been on Medicare or Medicaid _____.
4. Patient must be treated on an outpatient basis.
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 requires a statement attached to your application with the following information.
 - What have you been experiencing with your health challenges.
 - Describe your last 3 years of employment and your career.
 - The Clinic of Angels goal in providing financial assistance is to help the individual return to a productive life. In a paragraph explain why you feel that you should be chosen for this assistance.

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, any type of Pain Medication, Vitamin or Nutritional Supplements, and the like. We also will not provide the funds for palliative care.

The Clinic does not cover physician or healthcare provider office fees. Labs and some diagnostic studies will be considered on a case by case basis as it relates to treatment.

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, any type of Pain Medication, 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 _____

TO BE COMPLETED BY YOUR PHYSICIAN

Diagnosis _____

Prognosis _____

Treatment Orders:

- _____
- _____
- _____
- _____

Approximate Length of Therapy:

Physician Signature _____

Date : _____

Official Use Only

Reviewed by Committee _____

Date _____

Accepted _____ Pending _____ Rejected _____

Please forward your completed application and all
necessary papers to:

The Clinic of Angels
9804 n. 56th Street
Tampa, FL 33617
Phone: 813-980-1236

Or scan and email to :
ClinicofAngels@gmail.com