GRANT APPLICATION FOR NON-REIMBURSED MEDICAL/PRESCRIPTION DRUG EXPENSES

Documentation must be included for the non-reimbursed medical/prescription drug expenses for which you are requesting a grant.

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Name: _____ Date: _____

Address: _____

Telephone: _____ Email: _____

Dependents-Please include names and ages: _____

Next of Kin or Whom to Contact in an Emergency:

Name: _____ Telephone: _____

Address: _____

Date of ABC/USA Ordination: _____ Church: _____

Location and Dates of Service in Massachusetts: _____

Present Church Membership: _____

_____

_____

Describe the illness and/or condition for which the expenses were incurred.

_____

_____

_____

_____

_____

Explain why expenses were not covered by insurance and/or Medicare/Medicaid.

_____

_____

_____

_____

Explain need for the grant:

_____

_____

I certify that the above information is correct.

Signature of Applicant: _____ **Date:** _____

Please return to: Douglas Tatreau 69 Fort Point Road North Weymouth, MA 02191

If you have questions, please call me at: 781-664-4266

Health Insurance Carrier:

Medicaid/Medicare: Yes No Plan

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