APPLICATION FOR MEDICAL AID

Child's Name: _____

Address: _____

_____

Contact Phone for application: _____

Email address: _____

THE B.F. AND ROSE H. PERKINS FOUNDATION

45 E. Loucks Street, Suite 110

P.O. Box 1064

Sheridan, WY 82801

Office & Text line: (307)674-8871

Email: perkinsfoundation@fiberpipe.net

APPLICATION FOR MEDICAL AID

RULES AND REGULATIONS:

1. Applicant must have resided in Sheridan County, Wyoming for at least 1 year and be over the age of 1 year and under the age 21 years.
2. All applications must have prior board approval before any funds will be advanced.
3. Applicant must show financial need.
4. Grants are subject to the Foundation's Will and bylaws and rules and regulations adopted by the Board of Directors.

IS INSURANCE AVAILABLE? YES ☐ NO ☐

Name of Insurance Company and Policy Number or Group Number: _____

_____

Estimated amount of insurance payment for this request: $_____

List other organizations and/or agencies where applications for funds have been or will be submitted:

_____

_____

_____

IF THIS APPLICATION FOR MEDICAL AID IS GRANTED,
I AGREE TO ABIDE BY THE RULES AND REGULATIONS STATED ABOVE.

DATED: _____ _____

(SIGNATURE OF APPLICANT IN FULL)

_____ _____

(PARENT'S ADDRESS) (SIGNATURE OF PARENT/GUARDIAN)

_____ _____

(PARENT'S ADDRESS) (SIGNATURE OF PARENT/GUARDIAN)

IN ORDER TO QUALIFY FOR FINANCIAL ASSISTANCE, APPLICANT AND PARENTS OR GUARDIANS MUST HAVE COMPLETED AND SIGNED THE APPLICATION FORM AND SUBMITTED A COPY OF THEIR MOST RECENT FEDERAL TAX RETURN. IF APPLICANT, PARENT OR GUARDIAN HAS NOT FILED A FEDERAL TAX RETURN, PLEASE STATE SO.

Applicant remains free to select health care providers of their choice. The Foundation may consider comparative costs of various providers in determining which applications to approve and amounts to be granted. The Foundation may request a second opinion from another health care provider to help determine need and cost.

B.F and ROSE H. PERKINS FOUNDATION ~ SHERIDAN, WYOMING

APPLICATION FOR MEDICAL AID

(No payment will be made without prior board approval.)

Name of Child: _____ **Date of Birth:** _____ **Current Age:** _____

Sex: _____ **Social Security Number:** _____

Number of years child has lived in Sheridan County: _____

Fathers (Guardian) Name: _____

Address: _____

Social Security Number: _____

Married ☐ **Divorced** ☐ **Single** ☐ **Deceased** ☐

Is child support being received? $_____

Number of Dependents living at home: _____

Ages: _____

Number of years living in Sheridan County: _____

Do you Own your home ☐ **or Rent** ☐

Employer: _____

Address: _____

Phone: _____

Occupation: _____

Number of years at present job: _____

Income: $_____

Other Income: $_____

Previous Employer if less than 2 years on present:

Previous Employer: _____

Occupation: _____

Total Amount of all Assets Owned: $_____

Total Amount of All Liabilities: $_____

_____

Signature

Mothers (Guardian) Name: _____

Address: _____

Social Security Number: _____

Married ☐ **Divorced** ☐ **Single** ☐ **Deceased** ☐

Is child support being received? $_____

Number of Dependents living at home: _____

Ages: _____

Number of years living in Sheridan County: _____

Do you Own your home ☐ **or Rent** ☐

Employer: _____

Address: _____

Phone: _____

Occupation: _____

Number of years at present job: _____

Income: $_____

Other Income: $_____

Previous Employer if less than 2 years on present:

Previous Employer: _____

Occupation: _____

Total Amount of all Assets Owned: $_____

Total Amount of All Liabilities: $_____

_____

Signature

APPLICATION FOR MEDICAL AID

B.F. AND ROSE H. PERKINS FOUNDATION

Medical - Dental Form (to be filled out by Provider) or Attach Provider's Treatment Plan

Patient's Name: _____

Female: _____ **Male:** _____ **Age:** _____

Nature of illness, disease or defect for which grant is requested:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Estimated time and total cost of treatment: _____ $_____

I, _____ agree to the release of my health information to B.F. and Rose H. Perkins Foundation and to the Foundations referring specialist for review as to the specific reason for this request. I understand this may include my health history, radiographs and other test results deemed to impact my overall health by the delivery of these medical services.

_____ **Date:** _____

(SIGNATURE OF APPLICANT OR SIGNATURE OF PARENT/GUARDIAN (OF MINOR)

I believe the Patient can be improved sufficiently to warrant the medical treatment recommended by me.

Doctor or Dentist Signature: _____

Date: _____

Doctor or Dentist Name: _____

Address: _____

Phone: ( ) _____ **Email: **required**** _____

APPLICATION FOR MEDICAL AID

AGREEMENT OF APPLICANT, PARENTS/GUARDIAN

In making application for aid, I hereby agree to give my written consent for self or minor child to receive treatment as requested. I recognize the medical need of self or my child indicated herein by Dr._____.

I/We are requesting medical, dental aid, with the understanding that all changes require prior Board approval.

I/We agree to the release of my health information to B.F. and Rose H. Perkins Foundation and to the Foundations referring specialist for review as to the specific reason for this request. I understand this may include my health history, radiographs and other test results deemed to impact my overall health by the delivery of these medical services.

_____

Applicant

_____

Father or Guardian

_____

Mother or Guardian

(for Trustees Only)

ACTION OF TRUSTEES

MEDICAL – DENTAL

We, the Trustees of the B.F. and Rose H. Perkins Foundation have duly investigated the eligibility of the named applicant for medical – dental aid. The Trustees have found the applicant to be _____eligible _____ineligible for aid in accordance with the requirements of the Foundation and the application is hereby approved/disapproved for the sum of: $_____.

_____

CHAIRMAN

_____

_____

_____

_____