



OF THE GREATER WASHINGTON METROPOLITAN AREA

PO BOX 3241881 Bethesda MD 20827-1881

Please attach current patient photograph

Application Date _____

Medical Financial Assistance Application

Patient's Name _____ Male Female Date of Birth _____

Patient's Social Security No. _____ Immigration Status _____ (if applicable)

Parent's/Guardian Name(s) _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ Parish _____

PERSONAL REFERENCES: Please include name, address & telephone number

- 1) _____
2) _____

ATTENDING PHYSICIAN'S INFORMATION:

Name _____ Address _____

Referred to AGAPE Foundation by _____

Present Illness or Medical Problem _____

MEDICAL HISTORY: Please include dates when possible

Has patient received financial assistance from any Philoptochos Chapter or National Philoptochos?

Yes No If yes, please explain _____

INSURANCE COVERAGE INFORMATION: Primary _____

Please attach physician's report and any pertinent information regarding medical insurance coverage or lack thereof. Secondary _____

GREATER WASHINGTON AREA PHILOPTOCHOS SOCIETIES