

EPISCOPAL YOUTH & CHILDREN'S SERVICES

611 East Bay Street, Savannah, GA 31401

EMERGENCY OR MEDICAL FINANCIAL AID APPLICATION

Please fill out form completely

Date _____

Name _____ Sex ____ Age _____

Date of Birth _____ Social Security # _____

Address _____

_____ Phone _____

Home Parish/Mission _____

Address _____ Phone _____

Mother's Name _____

Employment _____

Address(if different) _____

Father's Name _____

Employment _____

Address(if different) _____

Number in family (including dependent siblings and ages) _____

Physician's Name and Address _____

_____ Phone _____

Applicant must include a copy of the current 1040 from the person/persons financially responsible for the applicant. Unforeseen financial circumstances encountered during the past year should be reported. Please attach this information to the application.

Attached is a copy of (check all that apply)

Father's 1040 _____ Mother's 1040 _____ Joint Parental 1040 _____

Primary Medical Insurance _____

Secondary Medical Insurance _____

Briefly explain situation and need for assistance:

Amount of financial assistance requested _____

Estimated Length of Need/Treatment _____

Evaluation from Parish/Mission Priest

Sponsoring Priest _____ Date _____

Parish/Mission(if different from Home Parish/Mission) _____

Address _____ Phone _____

I certify that the information given above is true and correct. I hereby authorize the release of medical information regarding this application to the EYCS.

Date _____ Applicant's Signature _____

Relationship _____ Name (printed) _____