CHILDREN'S AGAPE FOUNDATION

OF THE GREATER WASHINGTON METROPOLITAN AREA

PO BOX 341881
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