CONFIDENTIAL

THE WILLIAM J. MUNSON FUND

WATERTOWN, CONNECTICUT 06795

APPLICATION FOR MEDICAL / DENTAL ASSISTANCE

(MUST BE FILLED-IN COMPLETELY – PLEASE PRINT)

DATE:______________________________

PATIENT NAME:____ **AGE:**________

ADDRESS:____ **TOWN:**____________________

PHONE #:____________________________ **RESIDENCY:** Years in Watertown:__________________

TOTAL FAMILY INCOME (Include Social Security, Pensions, etc.)

$_______________________________ week / month / year *(PLEASE CIRCLE ONE)*

TOTAL FAMILY OBLIGATIONS (Rent, food, clothes, heat, car, etc.)

$_______________________________ week / month / year *(PLEASE CIRCLE ONE)*

Dollars available for this expense item from-
TOTAL FAMILY SUPPORT SYSTEM:

NAME	**AMOUNT AVAILABLE**	*(PLEASE CIRCLE ONE)*
Self:____________________	$______________	week / month / year
Spouse:__________________	$______________	week / month / year
Children:_________________	$______________	week / month / year
Children:_________________	$______________	week / month / year
Other:___________________ List Source	$______________	week / month / year

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LIST AND ATTACH BILLS BY CARE-GIVER. BILLS MUST SHOW PROCEDURE, DATE OF SERVICE, AND AMOUNT STILL DUE AFTER INSURANCE PAYMENTS, ETC.

CARE-GIVER	**AMOUNT DUE**
______________________________	$________________
______________________________	$________________
______________________________	$________________

NET AMOUNT OF ATTACHED BILLS: $____________________

NOTE: IF MORE SPACE IS NEEDED, CHECK HERE AND LIST ON BACK OF PAGE:______________

Other pertinent information that would assist the Trustees in considering this request should be submitted by a third party, other than the Care-Giver and the Applicant, who can substantiate the hardship:

Recommended by:____ Title:_________________

Date:________________________ Contact Number:________________________________