# EQUISTRIAN AID
# APPLICATION FOR ASSISTANCE

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**GENERAL INFORMATION**:

Complete Name: _____

E-mail Address: _____ Social Security #: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____ City: _____ St: ____ Zip Code: _____

Assistance Requirements: (*Describe specific assistance being requested)*_____

_____

_____

_____

_____

Assistance Length: *(Approximate length of time assist)* _____

_____

**EMPLOYMENT INFORMATION**

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Work Telephone: _____ Cell Phone: _____

MEDICAL INFORMATION:

Nature of Illness: *(Please provide brief description of illness)* _____

_____

_____

Physician's Name: _____

Physician's Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

☐ I hereby grant permission to my physician to release any medical information.

**INSURANCE INFORMATION**

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company Phone No.: _____ Cell Phone No.: _____

Type of Policy: _____

**INCOME INFORMATION (PER MONTH BASIS)**

Income Amount: $_____

Supplemental Income Amount: $_____ Type: _____

_____

☐ I hereby certify that the information provided about is true, and that I am the sole beneficiary of my assistance that is granted by the application.

Printed Name: _____

Signed: _____

Date: _____

SPIRIT THERAPIES
9140 LA MADRE WAY
LAS VEGAS NV 89149

Phone: 701-219-1728
Fax: 702 -562-9434
E-mail: horsemom59@hotmail.com