

EQUISTRIAN AID APPLICATION FOR ASSISTANCE

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

