C O N F I D E N T I A L

THE WILLIAM J. MUNSON FUND

WATERTOWN, CONNECTICUT 06795

APPLICATION FOR MEDICAL / DENTAL ASSISTANCE

FILL-IN COMPLETELY – PLEASE PRINT & RETURN TO LAURA GARAY -SENIOR CENTER and or JEANNE VICHIOLI- SOCIAL SERVICES
Send to: 61 Echo Lake Road Watertown, CT. 06795

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

List Source

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:_____