WYANDOT COUNTY
Council for Birth Defects

Application for Financial Assistance from Wyandot County Council for Birth Defects Upper Sandusky, Ohio 43351

1. NAME OF CHILD ______________________________
   LAST FIRST MIDDLE

   ☐ Male
   ☐ Female AGE ________ DATE OF BIRTH ____________ NICKNAME ____________

   PLACE OF BIRTH ______________________________

2. PARENT/GUARDIAN 1: ______________________________
   LAST FIRST MIDDLE

   ____
   STREET CITY ZIP COUNTY

   TELEPHONE: ______________________________ ____________
   HOME WORK MOBILE E-MAIL

   EMPLOYER ______________________________ TITLE ____________

   WORK ADDRESS ______________________________
   STREET CITY ZIP

3. PARENT/GUARDIAN 2: ______________________________
   LAST FIRST MIDDLE

   ____
   STREET CITY ZIP COUNTY

   TELEPHONE: ______________________________ ____________
   HOME WORK MOBILE E-MAIL

   EMPLOYER ______________________________ TITLE ____________

   WORK ADDRESS ______________________________
   STREET CITY ZIP

4. NAMES & AGES OF OTHER CHILDREN IN YOUR HOME: ______________________________

   ____

5. DIAGNOSIS OF DISEASE AND/OR DISABILITY AND AGE AT DIAGNOSIS:

   ____

   ____

6. OUTLINE OF FUNDING REQUESTED: Please be specific & include all costs if possible $____________

   A. Item or Service: ______________________________
   B. Supplier ______________________________
   C. Address of Supplier ______________________________
   D. Phone number ______________________________

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7. DOCTORS INVOLVED IN CHILD'S TREATMENT:

A. PRIMARY CARE-DOCTOR'S NAME____________________

NAME OF PRACTICE____________________

ADDRESS: ____________________ PHONE__________

B. SPECIALIST-DOCTOR'S NAME____________________

NAME OF PRACTICE____________________

ADDRESS: ____________________ PHONE__________

8. MEDICAL INSURANCE:

A. CARRIER: ____________________ MEMBER ID#__________

ADDRESS ____________________ PHONE__________

B. SECONDARY (if applicable)____________________ MEMBER ID#__________

ADDRESS ____________________ PHONE__________

9. AVERAGE MONTHLY INCOME: FATHER:__________ MOTHER:__________

I acknowledge that all information on this application is true, accurate and complete. I agree to notify Wyandot County Council for Birth Defects/Wyandot County Health Department if I move out of Wyandot County area and will provide updates regarding changes in my child's access to resources that could impact my need for continued funding with WCCFBD.

SIGNATURE OF PARENT/GUARDIAN____________________ **DATE**__________

Relationship to child: Circle One: Parent Grandparent Foster Parent Other __________

THIS SPACE IS FOR BOARD USE ONLY

Investigator:__________ **Amount of Check:**__________ **Check No:**__________

Approved:__________ **Date Check Sent:**__________

Date:__________ **Name of Doctor:** __________

Date Sent Applicant:__________ **Address:** __________

Date Rec. from Applicant:__________ **Phone:** __________