WYANDOT COUNTY
COUNCIL FOR BIRTH DEFECTS
UPPER SANDUSKY, OHIO

Application for financial assistance

Providing assitance to the children of Wyandot County with special needs since 1985.

DATE OF REGISTRATION

__ __ / __ __ / __ __

APPLICANT'S INFORMATION

Child's full name:

Nickname :

Place Of Birth :

Date of Birth : __ __ / __ __ / __ __

Current age:

Gender : ☐ Male ☐ Female

Disease and/or disability:

Age at diagnosis:

PARENT/GUARDIAN INFORMATION

Parent/guardian 1:

Address:

Zip:

County:

Home number:

Cell number:

Work number:

Email :

Employer:

Title:

Work address:

Zip:

Parent/guardian 2:

Address:

Zip:

County:

Home number:

Cell number:

Work number:

Email :

Employer:

Title:

Work address:

Zip:

Names/ages of other children in the home:

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OUTLINE OF FUNDING REQUESTED

Item or service:

Anticipated cost:

Supplier:

Supplier address:

Phone number:

DOCTORS INVOLVED IN CHILD'S TREATMENT

Primary care doctor:

Name of practice:

Address:

Phone:

Specialist doctor:

Name of practice:

Address:

Phone:

MEDICAL INSURANCE:

Carrier:

Member ID:

Address:

Phone:

Secondary:

Member ID:

Address:

Phone:

AVERAGE MONTHLY INCOME

Parent/Guardian 1:

Parent/Guardian 2:

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 Public Health if I move out of the 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 (mark one): Parent ☐ Grandparent ☐ Foster parent ☐ Other:

THIS SPACE IS FOR BOARD USE ONLY

Investigator:

Check amount:

Check No.:

Approved:

Date Check Sent:

Doctor name:

Date:

Address:

Date sent applicant:

Phone:

Date rec. from applicant: