Surviving NICU, Inc. - Application for Medical Assistance

NAME OF NICU PATIENT: _____

HOME ADDRESS: _____

HOME PHONE: _____

EMAIL: _____

DOB: _____

NAME OF PARENTS/CUSTODIANS: _____

NAME OF HOSPITAL/DOCTOR: _____

PAYMENT ADDRESS: _____

INVOICE AMOUNT: _____

Please attach, fax (914)788-9230, or email info@survivingnicu.org a copy of your hospital/doctor/laboratory bill AND the first two pages of your Form 1040. A representative from Surviving NICU will contact you to confirm your eligibility. Please note that all payments if any will be paid directly to the medical institutions. To be eligible for medical bill assistance the adjusted gross income of both parents may not be greater than $150,000.00.

For Office Use Only: