Application for Assistance

Justice McNeeley Foundation
P.O. Box 1675
Pine, AZ 85544

Date _____ Case No _____

Child's Name_____ Parent's Name(s)_____

Phone _____ Child's DOB_____ Child's Age _____

Address _____ Number in Household_____

Employer(s) _____

Who referred you to the Foundation? _____

Description of Child's Medical Need_____

_____

_____

What is the estimated cost of services?_____

How much of the cost can you furnish?_____

Amount requesting from the Foundation?_____

Name and contact information of service provider_____

_____

Have you contacted AHCCCS? Yes[ ] No [ ] What was the result?_____

Have you contacted CAP? Yes [ ] No [ ] What was the result?_____

Have you contacted other agencies? Yes[ ] No [ ] What was the end result? _____

Have you contacted the Foundation in the past year Yes [ ] No [ ]

Please provide an estimate or bill from medical provider(s)
Please provide copies of prescription forms (if appropriate)
Rev.0310/16 **Parent's Signature _____**