

# Mid-Coast Kid Application

Date of Application:

Applicant Name:

Date of Birth:

Sex: Male

Female

Street Address:

City:

State:

Zip:

Name of Person Filing Application:

Relationship to Applicant:

Contact Phone Number:

Street Address:

City:

State:

Zip:

Email:

Has the applicant received assistance from other organizations, entities, or groups in the past? If yes, please explain:

Does the applicant/family currently have insurance?

Does the applicant/family have an immediate financial need?

How has the diagnosis of the medical condition impacted the life of the applicant/family?

Questions/Comments:

How did you hear about Mid-Coast Smackdown?

Do you know a Mid-Coast Smackdown Board Member? If so, who?

Have you previously applied to for assistance from Mid-Coast Smackdown?

**Please attach a detailed history of the medical condition, including the grade and/or stage of condition, approximate time of original diagnosis, treatments to date, and prognosis if known. This application is considered incomplete without a detailed history of medical condition, and will not be considered.**

*By submitting this application, the person filing the application, and the applicant, agree to be contacted by a representative of the MCSD board for additional follow up. Mid-Coast Smackdown will not release nor sell any information obtained in this application.*

Name of Person Filing Application:

Signature:

Date:

*Applications can be sent to PO Box 39, Jourdanton, TX 78026, or MidCoastSmackdown@gmail.com.*