BOURBON COUNTY GOVERNMENT
APPLICATION FOR ASSISTANCE
CLIFTON GILLESPIE FUND

NAME OF PATIENT: _____ AGE: _____

ADDRESS: _____ INCOME: _____

_____

PARENTS OR SPOUSE: _____ AGE: _____

PHONE Number: _____ INCOME: _____

OCCUPATION: _____

OCCUPATION OF SPOUSE: _____

NUMBER OF DEPENDENTS: _____

MONTHLY PAYMENTS:

OWN HOME: _____

RENT: _____

UTILITIES: _____

INSURANCE: _____

OTHER: _____

OUTSTANDING DEBTS: _____

_____

_____

ASSETS: _____

_____

_____

DO YOU HAVE ANY KIND OF MEDICAL INSURANCE SUCH AS A MEDICAL CARD, MEDICARE, VETERANS INS, CIVIL SERVICE, ETC? _____

IF YES, PLEASE LIST _____

OTHER INFORMATION CONCERNING REQUEST FOR ASSISTANCE:

_____

_____

_____

ASSISTANCE PROVIDED: _____

REASON DENIED: _____

APPLICATION APPROVED BY: _____