Date:

Application for Assistance

Please complete the following questionnaire for review by Mary Payton's Miracle Foundation. Please mail completed form to the post office box listed at the bottom of the page or email to michelle@marypaytonsmiracle.com.

Family/individual in need of assistance: _____

Contact person's name: _____

Contact person's address: _____

Contact person's phone: cell:_____ other: _____

Please describe in detail why you are applying for assistance with Mary Payton's Miracle Foundation (attach additional pages if necessary) – letters from doctors are also helpful:

_____
_____
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_____

Medical bills per month not covered by insurance (please attach support):

_____
_____
_____

How did you hear about Mary Payton's Miracle Foundation?

_____
_____
_____

Mary Payton's Miracle reserves the right to ask for additional information, including information related to the applicant's financial situation or to independently verify the facts stated above with physicians or other professionals.