



Alliance Lions Club  
Alliance, NE 69301



Application For Individual Horspice Assistance

Date: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone No. \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Employment: \_\_\_\_\_

Homeowner: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Total Monthly Payment/Rent: \_\_\_\_\_

Reasons for Need of Financial Assistance: \_\_\_\_\_

Is this treatment recommended by a Physician, Medical Clinic or Facility Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide documentation. (Letter from physician, prescription, etc.)

Please state which Physician, Medical Clinic or Facility \_\_\_\_\_

Funding is limited and primarily given to those most in need. If you are not funded, will you proceed with this treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Applicant's (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_

Estimated Cost of Treatment \_\_\_\_\_

Horspice Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Lions Club Representative \_\_\_\_\_