WALPOLE EMERGENCY MEDICAL AID FUND

Established in 1940, Philip Allen donated the money to establish the Walpole Emergency Medical Aid Fund. The purpose of the fund is to help town residents pay for medical care that is not covered by public or private insurance or other funds. Any resident of the town of Walpole is eligible to receive funds. There is no obligation on the part of the recipient and all information is held in the strictest of confidences.

COVERED MEDICAL NEEDS INCLUDE:

- **Special Medical or Surgical Services**
- **Prescription Medicines**
- **Wheel Chairs**
- **Crutches**
- **Hearing Aids**
- **Dental Services**
- **Nursing Home/Respite Stays**
- **Special Nurses or Helpers**
- **Rehabilitation Treatments**

If you are a resident of the town of Walpole and are in need of emergency medical support, please contact a member of the Medical Aid Committee for information about the fund or to request an application.

MEDICAL AID COMMITTEE

Walpole Emergency Medical Aid Fund
P.O. Box 722
Walpole, MA 02081
or
WalpoleMedicalAid@gmail.com

EMERGENCY MEDICAL AID FUND

APPLICATION FOR AID

INSTRUCTIONS

Please complete both sides of this application. In order to properly review a request for consideration the following information is required.

APPLICATION INFORMATION

- Name of Applicant_____

  Date of Application_____ Age _____ Martial Status _____
- Address_____
- Telephone Number_____
- Please provide verification of residency (i.e. copy of phone, gas, electric, cable or water bill)
- Spouse Name_____ Age _____
- List Name and ages of other family members currently living in the household:

  _____

  _____

MEDICAL INFORMATION

- Name of current medical insurance company_____
- Recent Medical History:

  _____

  _____
- Reason for request:

  _____

  _____
- Please list outstanding medical bills:

  _____

  _____
- Please provide a copy of the itemized bill(s) that you are requesting aid for.

  Please note the fund does not make payments to individuals or collection agencies.

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REFERRAL INFORMATION

☐ Visiting Nurse ☐ School Nurse ☐ Council on Aging

☐ Clergy ☐ Other

- Name _____
- Telephone Number _____

VERIFICATION OF FINANCIAL NEED

Please complete this section if application has not been referred by a community agency

- Applicants Occupation _____
  Employer: Name, Address & Tel. # _____
- Spouses Occupation _____
  Employer: Name, Address & Tel. # _____
- *Please note that verification of financial need may be requested at a later date*

ADDITIONAL INFORMATION

- Have you received assistance from the WEMAF in the past?

☐ Yes ☐ No

If yes, in what year? _____

This information will assist committee members with record keeping

- Please list other information that may be significant when reviewing the application:

_____

_____

To the best of my knowledge the information contained in this application is true correct and complete

Signature of applicant: _____

Return the requested information to the following address:

Walpole Emergency Medical Aid Fund
P.O. Box 722
Walpole, MA 02081
or
WalpoleMedicalAid@gmail.com

A committee member will contact you as soon as your request is reviewed