SUPPORT SERVICES

APPLICATION

Name (First, Middle, Last): _____

Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Ext. _____

Email: _____

Employer: _____

Title: _____ Annual Household Income: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Ext. _____

Email: _____

REQUIREMENTS FOR APPLICANT

- Must be a patient diagnosed with Sickle Cell Disease that has been admitted for a SCD Crisis and must meet income criteria. Must be a resident of the State of Nevada, United States.

Patient Name (First, Middle, Last): _____
Date of Birth (Month/Date/Year): _____
Name of Healthcare Institution for Treatment: _____
Date Admitted: _____
Support Services Applying for: _____
Have you applied for Support Services before (check one): _____ Yes _____ No
Transportation Vouchers Requested (check one): _____ Yes _____ No
How did you learn about the HUGS Support Services: _____

RETURN APPLICATION TO:

US MAIL: HUGS Sickle Foundation, Inc., 6935 Aliante Pkwy, Suite 104-162, N. Las Vegas, NV 89084
EMAIL (send attachment in PDF format): hugsscf@yahoo.com **or FAX:** (702)924-0781