Mending Limbs Organization

Funding Application

Date:

Name:

Address:

Health Care Provider Name/Address:

_____

US Citizen:( ) yes ( ) no

In a minimum of 1,000 words, please tell us your story. Explain in detail exact reasons why your Health Insurance Provider will not cover your prosthesis. (please use additional pages if needed)

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Please note funding is based on an individual basis. The amount granted to the applicant will be based on donations received at annual benefit. There is not a guaranteed amount.

Submit Application Via Email or US Mail by October 1, 2010

MendingLimbs@yahoo.com
www.MendingLimbs.org

NEW ADDRESS- Mending Limbs Organization-214 Watson View Drive-Franklin, TN 37067