Aged Ministers Supplemental Application for Emergency Medical Assistance

General Council of the Assemblies of God

FULL NAME _____ **BIRTH DATE** _____ **AGE** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHONE NUMBER (_____)_____ **E-MAIL:** _____

EMERGENCY CONTACT _____ **Phone number** (_____)_____
(Other than your spouse) (Other than your home phone #)

Do we have a current Aged Ministers Assistance application on file for you? Yes or No _____
If NO, please complete an application and send it with this request form.

List all paid/unpaid medical expenses NOT covered by Medicare, Medicaid or insurance. You MUST include copies of receipts from your doctors, a pharmacy report of medicines received, hospital bills and other medical services. Requests for reimbursement will not be considered without receipts.

Medical Expense Item	Amt. Paid by Applicant	Unpaid Balance Due
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____
_____	$_____	$ _____

Comments or Questions: _____

_____

_____

I authorize Aged Ministers Assistance to confer with my emergency contact/ doctor/hospital regarding medical payments.

SIGNATURE OF APPLICANT _____ **DATE** _____

FAX this to AMA – 417-862-3439 or mail to

Aged Ministers Assistance, General Council of the Assemblies of God
1445 N. Boonville Ave., Springfield, MO 65802-1894

Ph: 417-862-2781, ext 2184 E-mail: ama@ag.org Website: www.ama.ag.org