Aged Ministers Supplemental Application for Medical Assistance

General Council of the Assemblies of God

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

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

YOUR PHONE NUMBER _____ **E-MAIL:** _____

Since approval of a Medical Assistance application is based upon <u>your available resources</u>, please provide the following information: Amt. in Checking Acct: _____
Amt. in Savings Acct: _____ Amt. in <u>MBA</u> or retirement Acct: _____.

List all paid/unpaid medical expenses NOT covered by Medicare, Medicaid or insurance. You MUST include copies of receipts from your doctors, <u>a pharmacy report of medicines received</u>, hospital bills and other medical services. <u>Requests for reimbursement will not be considered without receipts</u>. <u>For prescriptions, please provide a printed report from the pharmacy by year, not the individual prescription receipts</u>. Call and ask them for the report… they will provide it for you.

Provider	Date	$ Total	$ Paid	$ Due

Comments or Questions:

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

SIGNATURE OF APPLICANT _____ **DATE** _____

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: <u>ama@ag.org</u> Website: <u>www.ama.ag.org</u>