CRMC
CUYUNA REGIONAL MEDICAL CENTER
Dedicated to You. Every Day.

Courage Cabinet Application

Please Print:

Name:_____
(Last) *(First)* *(Middle initial)*

Birthdate:_____/_____/_____
(Month) *(Day)* *(Year)*

Primary Care Physician:_____

Address:_____ City:_____ State:_____ Zip:_____

County:_____ Home Phone:_____

Reason for Request:_____

_____

_____

Type of diagnosis: _____

Are you currently receiving treatment for your diagnosis? ☐ YES ☐ NO

Financial barriers or other circumstances for consideration:

_____

_____

Do you have any health insurance: ☐ YES ☐ NO

If yes, please list the insurance:_____

What is your total monthly household income before taxes: $_____per month.

**Note: if you farm, are self-employed, use net income (after deducting business expenses)*

Including you, how many people are supported by this income?_____

Signature:_____ Date:_____

For Office Use Only:

Reviewed By:_____ Date:_____

Eligible: ❒ YES ❒ NO Amount Awarded:_____