

Financial Assistance

Endowment Funds Application

HARRIET B. CULLEN GRANT APPLICATION

Print this page, complete, and submit application with copy of previous year.

Income Tax Return to:

Upstate New York Transplant Services, Inc.

110 Broadway

Buffalo, NY 14203

or fax to 716-348-5432

If you have any questions about the application process, please call 716-853-6667.

Name: _____

Phone: _____

Address: _____

Employer: _____

Address: _____

Gross Income: _____

Social Security #: _____

Did you file a state and/or federal income tax return in the past 12 months? _____

If yes, attach copy.

Date of Birth: _____

Married: _____ Single _____

Number and Age of Dependents: _____

Health Insurance: _____

Medicare: _____

Medicaid: _____

Condition Requiring Treatment (must relate to eye sight):

Charge Code(s)(Obtained from Provider of Service):

Nature of Treatment Needed:

Provider of Service Requiring Payment:

Phone # _____

Address of Provider:

If application is being made by someone other than above applicant, please provide:

Name: _____

Relationship: _____

Phone Number: _____

I certify that the above information is true to the best of my knowledge.

I agree to any investigation made by Upstate New York Transplant Services, Inc., to verify or confirm the information in connection with my request for aid from the Harriet B. Cullen Fund.

Signature: _____

Date: _____

