"JIMMY MOORE"
EMERGENCY MEDICAL ASSISTANCE FUND
FUNDING REQUEST FORM

NAME: ______________________________ DATE: ______________

ADDRESS: ______________________________ PHONE: ______________

CITY: ________________ STATE: __________ ZIP: __________

Referred By: ____

Referral Agency, if applicable: ______________________________

Amount Requested: $_________.____

Reason for Request: ______________________________________

____

____

The **ISGCBI JIMMY FUND** WILL ONLY PAY FOR SERVICES THAT ARE AUTHORIZED IN ADVANCE. Requests for services to be provided must be sent to **ISGCBI, PO Box 6338, Boise, ID 83702-6338.**

Verification of Status: ____________________________________

____

(signature of provider, health department record, copy of test, etc)

Check Payable to: ____

Address: ____

Authorization Signature: ___________________________________

Account Number: ______________