



Kashmiri Overseas Association, Inc.

www.koausa.org

A non-profit organization registered in the state of Maryland. Exempt from Federal Income tax under section 501(c)(3) of the Internal Revenue Code.

K.O.A. Medical Fund Application (Page 1 of 2)

(This Page To Be Filled Only By The Patient)

Patient Data:

1. **Application Date:** _____
2. **Name:** _____ **Age:** _____
3. **Address:** _____ **Tel. No.** _____
Fax No. _____
4. **Parents' Names (if younger than 21 yrs. old):** _____

5. **Occupation:** _____
6. **Employer:** _____
7. **Years With This Employer:** _____ **Total Years Working:** _____

Patient Income Data:

1. **Monthly Salary:** _____
2. **Other Income:** _____
3. **Total Income Per Month:** _____

Patient's Illness Expenditure Data:

1. **Monthly Expenditure On Medicines:** _____ **Monthly Doctor's Fees:** _____
2. **Monthly Hospital Fees:** _____
3. **Other Illness Expenditures:** _____
4. **Total Monthly Illness Expenditures:** _____

Person Other Than The Patient Filling This Application:

1. **Name:** _____ **Address:** _____
2. **Relationship With The Patient:** _____

Applicant's Signature: _____

**Signature Of The
Person Applying
For The Patient:** _____

KOA Verification: _____



Kashmiri Overseas Association, Inc.

Office of the President, 2117 Fresian Ct NE, Grand Rapids MI 49505

Tel: 616-365-9439 (Res)

<http://www.koausa.org> , e-mail: president@koausa.org



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K.O.A. Medical Fund Application (Page 2 of 2)

(This Page To Be Filled Only By The Physician(s) Attending On The Patient)

Attending Physician's Data:

1. **Date:** _____
2. **Name:** _____
3. **Hospital Or Clinic's Name And Address Where The Physician Practices:**

4. (a). **Tele. No.** _____ 4 (b). **Fax. No:** _____
5. **Area of Specialization:** _____

Patient Data:

1. **Patient's Name:** _____
2. **How Long Has The Physician Treated The Patient ?:** _____
3. **Patient's Illness Diagnosis:** _____

4. **Illness Prognosis:** _____
5. **Treatment Prescribed:** _____
- 6 (a). **Is Hospitalization Required ?:** _____ 6 (b). **How Long ?:** _____
7. **Monthly Cost Of The Treatment:**
(Medicines Plus Doctors' Fees
Plus Hospital Expenditures): _____
8. **Other Costs Associated With
The Treatment Per Month:** _____
9. **Total Costs Per Month:** _____
10. **Can The Patient Work Now?** _____
11. **If Not, How Much Time Later:** _____
- 12 (a). **Physician's Signature:** _____ 12 (b). **KOA Verification:** _____



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