Gas Assistance Application

1. Expecting mother or parent's FULL NAME _____
2. Due date or birth date of child_____
3. Please select to what visit you are requesting gas assistance.
   - ☐ Prenatal
   - ☐ Postpartum (mother up to 2 months postpartum with exception for mental health)
   - ☐ Well-child visit (infant up to 1 year of age)
4. Doctor's name _____
5. Town in which the doctor's visit will take place _____

Please read the following statement and sign below if you confirm it to be true.
I am needing assistance with gas cost for the health care visit listed above. I am not accepting other resources to assist with gas currently. _____

FOR DOCTOR:

I, (Doctors name) _____, saw (patient's name) _____ on (date) _____ at (town/location) _____.

Doctors printed name_____& signature _____

**To continue to receive funds, this form with doctors' signature must be turned back into the Regional Healthcare Foundation in person, fax 573-614-4908, or scan to rachelleb@regionalhf.org

FOR STAFF: {Rachelle Bennett, rachelleb@regionalhf.org, 624-1607}
REQUIREMENTS

- ☐ *Be a resident of Stoddard County*
- ☐ *In need of gas assistance for transportation to prenatal, postpartum, or infant doctor's appointment. (circle which applies)*
- ☐ *Be able to present identification in the form of a picture id or utility bill with their name and current address proving residency in Stoddard County.*

1. List applicant's **name** and **address** as shown on picture id or utility bill (dated within the last month).
   _____

2. What amount does individual qualify for looking at their home address vs. location of doctor visit?
   20 to 70 miles roundtrip =$20
   70+ miles roundtrip=$40
   - ☐ $20
   - ☐ $40

Staff signature _____ Date gas certificate was distributed _____