Equestrian Aid Foundation

APPLICATION FOR ASSISTANCE - PRINT

Please complete and MAIL this form to Janise Gray, Director of Grant Recipient Services, 228 Phillips Terrace, Union, NJ 07083, FAX it to 908.964.6088, or SCAN AND EMAIL the form to Janise@EquestrianAid.org. If you have questions, please contact Equestrian Aid's Director of Grant Recipient Services at Janise@EquestrianAid.org or by telephone: 908.803.1535 or 800.792.6068.

PERSONAL INFORMATION

NAME			DATE
ADDRESS			PRIMARY PHONE # ______________________________ ☐ cell ☐ home ☐ other _____________
			EMAIL
GENDER ☐ female ☐ male	MARITAL STATUS ☐ single ☐ married ☐ domestic partner ☐ separated ☐ divorced	DEPENDENTS/RELATIONSHIP Names / ages	CONTACT INFORMATION – family member or friend Name ____ Phone ____ Email ____
DATE OF BIRTH		LIST MEMBERS OF HOUSEHOLD	
PLACE OF BIRTH			
U.S. CITIZEN ☐ yes ☐ no	Country of Citizenship		
WHO REFERRED YOU OR HOW DID YOU HEAR ABOUT THE EAF?		DISCIPLINE - mark all that apply ☐ dressage ☐ endurance ☐ hunter/jumper ☐ other (list) ☐ driving ☐ eventing ☐ reining	

MEDICAL INFORMATION

NATURE OF ILLNESS / INJURY - please provide brief description of illness/injury

ASSISTANCE REQUIREMENTS

DESCRIBE SPECIFIC ASSISTANCE BEING REQUESTED	APPROX LENGTH OF TIME assistance is requested

MEDICAL INSURANCE INFORMATION

PROVIDER'S NAME, ADDRESS, POLICY TYPE AND DATES	INSURANCE PROVIDER'S TELEPHONE #

EMPLOYMENT (if any)

EMPLOYER'S NAME AND ADDRESS	EMPLOYER'S PHONE #