ROHHAD FIGHT INC.

3 Surrey Lane
Hempstead, NY 11550
rohhadfight@aol.com

APPLICATION FOR ASSISTANCE

____ is a ________ year old boy/girl diagnosed with ROHHAD Rapid-onset Obesity with Hypothalamic Dysfunction, Hypoventilation and Autonomic Dysregulation (ROHHAD syndrome).

Date of diagnosis ____________________________________age at diagnosis ____

Diagnosed by ____________________________________, whose phone # is____

Currently under the care of ___________________________, whose phone # is____

As a result of ROHHAD, we have encountered difficulties in meeting our expenses and are seeking assistance for the following medical bills:

1. ____
2. ____
3. ____

As a result of ROHHAD, we have encountered difficulties in meeting our expenses and are seeking assistance for the following travel/other expenses:

1. ____
2. ____
3. ____

Please use the following space to include any extenuating circumstances that you feel may be relevant to your request.
____
____

Please provide all parent contact information so that we may be able to contact you.

Name____Preferred Contact method______________________________________

Address____

Home phone #____________________Cell Phone #_____________________Email ______________________________________

X____ ____
Parent or Guardian Signature Print Name

<u>ALL APPLICATIONS MUST INCLUDE A LETTER FROM THE DOCTOR SUPPORTING YOUR DIAGNOSIS AS WELL AS COPIES OF BILLS TO SUBSTANTIATE ASSISTANCE REQUESTED.</u>

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FOR OFFICIAL USE ONLY

Date Received______________________________ Reviewed by____
Date Response was given____________________ Disbursement made ___________________________________

APPROVAL IS BASED UPON THE DISCRETION OF THE BOARD AS WELL AS THE AMOUNT OF FUNDS AVAILABLE AT THE TIME OF APPLICATION.

PLEASE MAIL OR EMAIL YOUR REQUEST TO THE ABOVE ADDRESS.