NDES
FOUNDATION

HEALTH CARE ASSISTANCE APPLICATION FORM

A. PERSONAL INFORMATION.

1. Name:_____
2. Sex: Male ☐ Female ☐
3. Father's name: _____TEL: _____
4. Mother's name: _____TEL: _____
5. Name of Guardian: _____TEL: _____
6. Region of Origin: _____Village_____
7. Residence: _____
8. Age: _____

B. MEDICAL BACKGROUND.

1. What are you currently sick of: _____
2. Amount applied for: _____
3. Medical conditions:Tick all that apply to you.

Medical Condition	Yes/No		Medical Condition	Yes/No		Medical Condition	Yes/No	
Cancer			Diabetes			Tuberculosis		
Sickler			Heart Disease			Asmathic		
Stroke			High Blood Pressure			Hepatitis		

4. Have you ever had any type of surgery before? Yes: ☐ No: ☐
5. Are you a heavy drinker of alcohol? Yes: ☐ No: ☐

C. **FINANCIAL BACKGROUND**

In the space provided below, describe in less than 500 words your financial background and what makes you eligible for health assistance.

D. MEDICAL HISTORY

In the space provided below, describe in not more than 500 words your medical history.