



### **Application for Assistance – Confidential**

To be considered for assistance through The David Lytle Memorial Foundation, please make sure that all sections are complete and all required signatures are included. Send the completed application with the signed "Publicity Release" to the address indicated at the end of the form.

Participant's Name:

---

First	Middle	Last
-------	--------	------

Home Address:

---

Street	City	State	Zip
--------	------	-------	-----

Home Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred By: \_\_\_\_\_

#### **Medical Information**

Please attach documentation verifying the level of your spinal cord injury for verification purposes.

Physician's Name: \_\_\_\_\_ Facility: \_\_\_\_\_

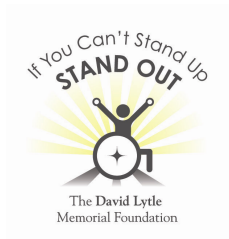
Phone: \_\_\_\_\_

Nurse/Social Worker: \_\_\_\_\_ Facility: \_\_\_\_\_

Phone: \_\_\_\_\_







Please read and sign below. Make sure to have your signature witnessed and dated.

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of The David Lytle Memorial Foundation regarding the assistance I am requesting.

I understand and agree to cooperate with all requests from The David Lytle Memorial Foundation for medical information necessary to verify my spinal cord injury, including signing any necessary consent/authorization forms. The Foundation agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their express permission.

I understand and agree that fulfillment of assistance may result in publicity whether or not The David Lytle Memorial Foundation actively takes steps to publicize its service.

I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by The David Lytle Memorial Foundation.

I also understand that there is a limit to the number of services that I will receive, depending on the type and cost of service being requested and offered.

I verify that I do have a spinal cord injury.

\_\_\_\_\_  
Participant Date Witness Date

\_\_\_\_\_  
Spouse (if participant is unable to complete) Date

Service Requested: \_\_\_\_\_

Amount Requested: \_\_\_\_\_

**Please mail this form to:**

The David Lytle Memorial Foundation  
117 Public Square  
Medina, OH 44256