福音真理基金會
CHRISTIAN GOSPEL TRUTH FOUNDATION, INC.
FAITHFUL STEWARDS OF GOD'S BLESSINGS • 1965

25 Doña Hemady Ave., cor. 3rd St.,
New Manila, Quezon City, Philippines

Tel.: (632) 8294-0853 to 55 loc. 110

DSWD-SB-R-00036-2024
DSWD-SB-L-00065-2024

MEDICAL ASSISTANCE APPLICATION FORM

Name of Patient

Last Name	First Name	Middle Name

Date of Application

Birthday

Age

Endorsed By / Date

Requested by

☐ JEC ☐ JCAI ☐ CGTFI

Relationship to Patient

☐ SPOUSE ☐ PARENT ☐ CHILD ☐ RELATIVE

Contact Number

Surgery As ☐ Out – Patient ☐ In – Patient

Hospital

☐ **Approved by CGTFI Health Committee**

Requirements Checklist

_____ 1. Medical Abstract from attending physician
_____ 2. Supporting diagnostic results (e.g., laboratory test, MRI, scan, xray)
_____ 3. Photocopy of government issued ID of patient
_____ 4. Authorization Letter and photocopy of government-issued ID, if representative (only immediate family member) to receive check
_____ 5. Letter of authorization from patient. If needed to deposit check to patient's bank account:
Bank Details (Account Name / Number)
_____ 6. After receipt of check, submit an acknowledgement letter / thank you note indicating amount received & utilization of the amount.

Documents Received By

KRISTYLLE MAE D. PASCUAL
Signature / Date

Approved for Check Release

EVELYN M. BUMATAY Executive Director
Signature / Date

Check Received By

Signature over printed name / Date

Form Revised: NOVEMBER 20, 2025