Attachment A
FACTMS Patient Assistance Fund Application

Clinic Name: _____

Contact: _____ Phone: _____

Email: _____

Address: _____

Describe expenses related to TMS therapy that your patient needs:

_____

- I agree to only support patients whose income level is less than or equal to 150% of the Federal Poverty Guidelines: yes/no
- I agree to provide a report on how funds were used within three months of receiving funds: yes/no
- I agree to provide a testimonial regarding how these funds have benefited my patient(s): yes/no

Name of Clinic Representative: _____

Signature of Clinic Representative: _____

Date: _____