

Team KJ Request for Assistance

Affected Persons Information

First Name: _____

Last Name: _____

Birth Date: _____

Gender: Male___ Female: ___

Phone: _____

Contact Information

Name: _____

Email: _____

Address: _____

City: _____

State/Zip: _____

Please fill out the following information and mail to:

Team KJ

PO Box

Pearl River, NY 10965

Once received, the application will be reviewed by a selection committee to determine how Team KJ can best assist you in your situation. Applications will be processed on a first come, first serve basis if funds are available. You will be notified promptly of any decision.

Have you been clinically diagnosed for HD? _____

Have you been genetically tested for HD? _____

If so, please provide the date of genetic diagnosis. _____

If you do not have HD provide a description of your medical condition.

Provide a description of the services or assistance you are requesting. Attach copies of receipts or invoices if available.