



## Clifton R. Lewis Good Life Foundation Application for Assistance

Name of person needing assistance: (Parent/Guardian also print below)

Date of birth:

Address:

Primary phone and email address:

Do you live in the continental United States?

Were you diagnosed with a type of Muscular Dystrophy? Diagnosis type?

Name, address, date and phone number of Doctor that made diagnosis:

Please explain your physical limitations:

In a few sentences, please explain your current situation and what your future goals are:  
(Separate sheet of paper)

What type of assistance have you received from the MDA, state and or/government?

Type of assistance needed: Please circle one below:

**Accessibility Assistance /Special Accessible Equipment /Dream Creator**

**Print name:**\_\_\_\_\_ **Sign name:**\_\_\_\_\_ **Date:**\_\_\_\_\_

All applications will be reviewed by the Clifton R. Lewis Good Life Foundation Board of Directors and decisions will be made within 30 days after receipt. All decisions will be made by email, phone or mail to the primary person(s) listed above.

*Please mail completed application to:*

**Clifton R Lewis Good Life Foundation  
PO Box 521 Tolleson, AZ 85353**

Please include a summary of situation, type of assistance needed and a recent photo.