Wellfleet Health/
Conservation Department

Provincetown Health
Department

Dexter Keezer Fund

BREASTFEEDING ASSISTANCE PROGRAM

ALL INFORMATION IS REQUIRED

DATE

Mother's Name	**Email Address**	**Telephone Number**	
Residential Address	**City/Town**	**State**	**Zip**
Mailing Address	**City/Town**	**State**	**Zip**
Baby's Name	**Baby's Date of Birth**		

List lactation support item(s) and/or service(s) for which you are seeking reimbursement ($150 maximum):

Date Purchased	Cost	Item or Service
TOTAL:		

ATTACH RECEIPTS OF ITEMS LISTED ABOVE

Eligibility Criteria reminder:

- **Purchase goods or services within 12 months of child's birth**
- **Submit for reimbursement within 18 months of child's birth**

MOTHER'S SIGNATURE	**NAME (PRINT)**	**DATE**

SUBMIT TO:

PROVINCETOWN HEALTH DEPARTMENT
260 COMMERCIAL STREET
PROVINCETOWN, MA 02657

FOR OFFICIAL USE ONLY

	DATE	INITIALS
RECEIVED		
HEALTH STAFF REVIEW		
VERIFY BIRTH WITH TOWN CLERK		
TOTAL REIMBURSEMENT AMOUNT	$	
INVOICE SUBMITTED TO FINANCE DEPARTMENT		