

**To be completed by referring professional:**

What are the special/extenuating circumstances causing this family to seek financial assistance?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please pick the category that best describes how this request benefits the individual?**

	Pay for pharmacy prescriptions not covered by insurance		Insurance co-payments (does not include co-insurance or deductibles)
	Pay past bills for gas, electric, water, propane and phone		Nutritional Assistance
	Pay past due rent/mortgage payments		Durable Medical Equipment (not covered by insurance)
	Insurance premiums [COBRA]premiums included		

To whom and where should the assistance be directed? \_\_\_\_\_

\_\_\_\_\_

Check made payable:

To Attention of: \_\_\_\_\_

To Attention of: \_\_\_\_\_

Acct No: \_\_\_\_\_

Acct No: \_\_\_\_\_

Mail Check to: \_\_\_\_\_

Mail Check to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

To Attention of: \_\_\_\_\_

To Attention of: \_\_\_\_\_

Acct No: \_\_\_\_\_

Acct No: \_\_\_\_\_

Mail Check to: \_\_\_\_\_

Mail Check to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

***I reviewed this application and I agree with the funding need.***

\_\_\_\_\_  
Referring professional -Print Name & Date

\_\_\_\_\_  
Referring professional -Signature

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Foundation Use Only:**

\_\_\_\_\_  
Print Name & Date

\_\_\_\_\_  
Signature

Check No: \_\_\_\_\_

Check Amount: \_\_\_\_\_

Check Date: \_\_\_\_\_

