APPLICATION FOR ASSISTANCE

APPLICANT INFORMATION

Today's Date:

Last Name:		First Name:		
Birth date:		Age:		☐ Male ☐ Female
Address:		City, State Zip:		
Lives with:	☐ Mother ☐ Father ☐ Both	Father's Name:		Mother's Name:
Home Phone:		Father's Cell:		Mother's Cell:
Father's Email:		Mother's Email:		
Other Family Contact Name:		Relationship:		Phone Number:
School:		Grade:		
Religious Preference:		Church Attends:		

DIAGNOSIS / TREATMENT INFORMATION

Date of Diagnosis:		Diagnosis:	
Hospital:		Treating Physician:	
Phone:		Fax:	
Case Manager or Social Worker:		Phone: Email:	

REFERRAL INFORMATION

Referred By:	☐ Parent/Guardian ☐ Physician ☐ Principal ☐ Minister/Pastor ☐ Other:______________			
Name:				
Phone:		Fax:		Cell:
Email:				

SIBLING INFORMATION

Name	Age/Birth date	Brother/Sister	School	Grade

Name of Parent/Guardian ______________ Signature of Parent/Guardian of the Child ______________ Date ______________

Please mail or fax Completed form to:
14720 Central Ave., Chino, CA 91710
Phone: 909-613-9161
Fax: 909-627-6735

Please note: Both the Application for Assistance AND Doctors Verification must be received at the Let It Be Foundation before the approval process can begin.

The Let It Be Foundation, Inc. – Office Only			
Received By:		Date:	
Scanned By:		Date:	
Board Approval		Date:	
Doctor Verification Requested:		Doctor Verification Received:	

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