

**APPLICATION POTENTIAL RECIPIENT INFORMATION**

\*All fields are required to be completed, if not applicable please enter n/a

Date of Submission:

Person/Organization Making the Request:

Email Address: Relationship to Recipient:

Address: Street City State Zip

Home Phone: Cell Phone:

How did you learn about the Umbrella Club?

Member Name:

Potential Recipient’s Name: Age:

 Have we ever helped this child before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recipient’s Diagnosis:

Description of Recipient’s needs:

Treatments and Therapies receiving:

Description of the financial assistance or resources you are requesting:

If you are requesting financial assistance, please provide an estimate of the cost from the provider:

Name/contact person of the provider you contacted (attach a written estimate if possible):

Name:

Address: Street City State Zip

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

Will any part of this item be covered by insurance? Yes/No

If yes, what is the total cost? \_\_\_\_\_\_\_\_\_\_\_ How much will insurance pay? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier Name: Insurance Policy Number:

Please indicate if any assistance is being received or will be received from any other foundation, agency or

fundraiser (Go Fund Me):

Employment Status Parent(s)/Guardian(s)? Yes/No

Primary Care Physician Name: Telephone Number:

Hospital:

Are you currently working with an Advocate? Yes/No

Name: Email Address:

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Approved Not Approved

Why?