APPLICATION FOR POTENTIAL RECIPIENT

Case Number:_____

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

Family Information:

Date of Submission*:_____

Parent/Guardian Name*:_____

Email Address*:_____Relationship to Recipient*:_____

Address*: Street_____ City_____ State_____ Zip_____

Contact Phone*:_____

Employment Status Parent(s)/Guardian(s)*: ☐Yes ☐No

If YES:

Name of Employer(s)*: _____

How many hours per week*: _____ Annual household income*: _____

Sources of Income and Assistance (List State and Federal Assistance and any other income sources, including online fundraising like GoFundMe)*:

_____

Monthly Bills: _____

Rent:_____ Utilities: _____ Other: _____

How did you learn about the Umbrella Club*: _____

Umbrella Club Member Name:_____

Application Submission Information:

Relationship to Recipient*: ☐Parent/Guardian ☐Social Worker ☐Advocate ☐Other

If NOT Parent/Guardian, complete the following:

Your Name*:_____ Email Address*:_____

Contact Phone*:_____ Relationship to Family*:_____

Are you also working with either: ☐Advocate ☐Social Worker

If EITHER:

Name*:_____ Email Address*:_____

Contact Phone*:_____

Does the Parent/Guardian speak and understand English*: ☐Yes ☐No

If NO, you will need to have an interpreter at our interview.

Potential Recipient Information:

Potential Recipient's Name*:_____ Age*:_____

Recipient's Diagnosis*:

_____

_____

Treatments and Therapies receiving*:

_____

_____

Have we ever helped this child and/or family before? ☐Yes ☐No

If YES:

What did we do*

_____

_____

What Assistance Are You Requesting:

Select All That Apply*: ☐Medical Bills ☐Equipment/Therapies ☐Household Bills ☐Transportation

What is the total cost*_____

Detailed Description of Assistance Requested (provide an estimate if possible)*:

_____

_____

_____

_____

Insurance Information:

Will any part of this item be covered by insurance*: ☐Yes ☐No ☐Unsure

If YES:

Insurance Carrier Name*:_____

How much will insurance cover* _____

Medical/Therapy Provider Contact Information:

Name*: _____

Address*: Street_____ City_____ State_____ Zip_____

Contact Phone:_____Email: _____

Primary Care Physician Name*: _____ Contact Phone*:_____

Hospital*:_____

Availability to meet by video: (Pick all applicable): ☐ Morning ☐ Afternoon ☐ Evening

The Umbrella Club
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www.Umbrellaclub.org

Approved:_____
Not Approved:_____
Why?_____