



Application For Assistance

Name of applicant		Date	
Father	Mother	Lives with	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
Address			
City	State	Zip	
Phone	Cell		
Birth Date	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
School	Grade		
Email			
Religious preference		Church Attends	

Diagnosis	Date of diagnosis		
Treating physician			
Hospital			
Physician's address			
City	State	Zip	
Phone	ext.	Fax	

Referred by: (To be completed by person referring)			
<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Physician	<input type="checkbox"/> Principal	<input type="checkbox"/> Minister/Pastor
Name			
Address			
City	State	Zip	
Phone	Fax		
Email			

Siblings living at home

Name	Age/Birthdate	Brother or Sister	Grade	School

Signature of parent/guardian of child

Date

The Let It Be Foundation, Inc. – office only

Confidential: Oct-06

Received by	Date
Board Comments	Physician Verification Received
Other	Physician Verification Requested