



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



Doctor Verification Form

This letter is to confirm that _____ was diagnosed
with _____ on this date _____.

His/her present prognosis is: ___good ___fair ___serious ___critical

Current treatment:

Other comments:

Physician's Name

Physician's Signature

Date

Physician's Address

City

State

Zip

*All the above information must be filled out completely to receive assistance

I, _____ give my permission to release
(Parent/Guardian of minor)

Diagnosis information of my child, _____.

Parent/Guardian Signature

Print Name

Date

Physician's office must mail in corporate envelope or fax completed form to:

The Let It Be Foundation

P.O. Box 730

Chino Hills, Ca 91709

909.613.9161 office

909.627.6735 fax