



**Disabled Child Support Request Application Form**

**Mission Statement: It is the mission of Patrick's Pals Foundation to give children with permanent multiple disabilities an opportunity to flourish in their individualized way.**

Application Date: \_\_\_\_\_ Applicant's Name: \_\_\_\_\_

Relationship to Child in need: \_\_\_\_\_ Applicant's Phone: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

Applicant's Email: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Address (if different from Applicant's):  
\_\_\_\_\_

Are you a patient of Children's Mountainside Rehab Tech Clinic? YES / NO

Description & Cost of Item or Service Requested: \_\_\_\_\_  
*(Please attach vendor or DME quotes)*

Describe benefits this Item or service provides:  
\_\_\_\_\_  
\_\_\_\_\_

Primary Insurance Co. name: \_\_\_\_\_  
Secondary Insurance Co. name: \_\_\_\_\_

Is this covered by insurance? \_\_\_\_\_ YES / NO  
Previously denied by Insurance? \_\_\_\_\_ YES / NO  
If YES (denied), please attach "Explanation of Benefits" form from insurance company

Please provide total 2017 household income: \_\_\_\_\_  
Number of dependents in household: \_\_\_\_\_  
(Salaries, Tips, Wages, SSI, etc.) W2's may be requested.

Please list the name and amount of any government sponsored financial assistance or subsidies you or the child currently receive: \_\_\_\_\_

Please allow 4 weeks for application review and response. Email application form and questions to [info@patrickspalsfoundation.com](mailto:info@patrickspalsfoundation.com)

For information about our organization please visit: [www.patrickspalsfoundation.com](http://www.patrickspalsfoundation.com)