



**Support Request Application Form**

**Mission Statement: It is the mission of Patrick's Pals Foundation to give children with 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

Are you a patient of Children's Hospital of Philadelphia? YES / NO

Description of Item or Service Requested: \_\_\_\_\_

Cost of Item or Service Requested: \_\_\_\_\_

**(IMPORTANT: Vendor or DME quotes MUST be attached for application to be considered)**

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

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

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

Is this covered by insurance? \_\_\_\_\_ YES / NO

If No, please attach copy of insurance denial

Please provide total 2018 household income: \_\_\_\_\_ (Salaries, Tips, Wages, SSI, etc.)

*Please attach copy of front page latest Federal Tax Return – front page with total AGI. NOTE: SS# should be blacked out.*

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 [request.application@patrick's-pals.com](mailto:request.application@patrick's-pals.com). For information about our organization please visit: [www.patrick's-pals.com](http://www.patrick's-pals.com)