



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. More info found at patricks-pals.com

Application Date: _____ Applicant's Name: _____

Applicant's Phone: _____ Relationship to Child in need: _____

Applicant's Address: _____

Applicant's Email: _____ Primary Language: _____

Child's Name: _____ Child's Date of Birth: _____

Child's Address (if different from Applicant's): _____

Have you been referred to Patrick's Pals by a person or organization? YES / NO
If yes, please indicate the referral source: _____

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 a copy of insurance denial
If partially covered by insurance, indicate expected insurance payment and attach EOB: _____

Please provide total 2020 household income: _____ Salaries, Tips, Wages, SSI, etc)

Please attach copy of front page of latest Federal Tax Return indicating AGI. 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 info@patricks-pals.com
For information about our organization please visit: www.patricks-pals.com