INTAKE APPLICATION

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Critically Ill Child's Name _____
Parent(s)/Guardian(s) Name _____
Address _____
Home Phone _____ Cell Phone(s) _____
Child's Age _____ Birthdate _____ Male/Female _____
Is the child a legal resident of the Commonwealth of Massachusetts? _____
Diagnosed Illness _____
Date Diagnosed _____
Brief description of treatment required at this time or in near future:

_____

_____

_____

Physician's Name _____
Physician's Phone _____ Affiliated Hospital _____
Hospital Social Worker's Name_____ Phone_____

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Annual Family Income_____ Number of Members in Household _____
Do you receive State Aid for this child? _____ What type? _____
Is there other money allocated for this child (Donations from anyone other than a relative, Assistance funds set up in your child's name, etc)?_____
If yes, please describe_____

_____

****

I hereby affirm the above information is correct

_____
Signature Parent/Guardian

****

FOR FUND USE:
Date Reviewed: _____ Approved: Yes No
Approved by: _____