

## MEDICAL INFORMATION

(To be completed by a social worker. You can type directly in to this document. If you submit a completely hand-written application, **PLEASE PRINT**)

Child's name: \_\_\_\_\_

Child's diagnosis: \_\_\_\_\_

Date of Diagnosis (**Month-Day-Year**): \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Worker's **Direct Phone Number and Extension**: \_\_\_\_\_

Please describe the child's medical condition, anticipated hospital stay, and any other notable facts (*please attach letter if needed*): \_\_\_\_\_

Has this family previously received assistance from The Change Reaction (Clark/Perlmans): \_\_\_\_\_

Social Worker Name and Title (**please print**): \_\_\_\_\_

\*Social Worker's **Hand-Written** Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Social Worker's Email Address (**please print**): \_\_\_\_\_

\* By signing this application, you are attesting to the accuracy of the information on both pages, to the best of your knowledge. Fraudulent applications may result in your institution being deemed ineligible for this program. Please be sure that the entire application is complete before submitting it.

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